

**Form 5500**Department of the Treasury  
Internal Revenue ServiceDepartment 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**2020****This Form is Open to Public  
Inspection****Part I Annual Report Identification Information**For calendar plan year 2020 or fiscal plan year beginning **04/01/2020** and ending **03/31/2021**

- A** This return/report is for:  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 ..... }
- D** Check box if filing under:  Form 5558  automatic extension  the DFVC program  
 special extension (enter description)

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan <b>Boston Plasterers' &amp; Cement Masons' Union Local 534 Pension Fund</b>	<b>1b</b> Three-digit plan number (PN) } <b>001</b>
	<b>1c</b> Effective date of plan <b>04/01/1962</b>
<b>2a</b> 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) <b>BOT-Boston Plasterers&amp;Cement Mason Union Local 534 Pension Fund</b>	<b>2b</b> Employer Identification Number (EIN) <b>04-6127786</b>
	<b>2c</b> Plan Sponsor's telephone number <b>617-825-4500</b>
<b>7 Frederika Street</b>	<b>2d</b> Business code (see instructions) <b>238900</b>
<b>Boston MA 02124</b>	

**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			<b>JAMES MULCAHY</b>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			<b>STEPHEN P. AFFANATO</b>
	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

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

Form 5500 (2020)

<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor		<b>3b</b> Administrator's EIN	
<b>Boston Plasterers' &amp; Cement Masons</b>		<b>04-6127786</b>	
<b>Union Local 534 Pension Fund</b>		<b>3c</b> Administrator's telephone number	
<b>7 Frederika Street</b>		<b>617-825-4500</b>	
<b>Boston MA 02124</b>			
<b>4</b> 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:		<b>4b</b> EIN	
<b>a</b> Sponsor's name		<b>4d</b> PN	
<b>c</b> Plan Name			
<b>5</b> Total number of participants at the beginning of the plan year		<b>5</b>	<b>548</b>
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).			
<b>a(1)</b> Total number of active participants at the beginning of the plan year .....		<b>6a(1)</b>	<b>255</b>
<b>a(2)</b> Total number of active participants at the end of the plan year .....		<b>6a(2)</b>	<b>243</b>
<b>b</b> Retired or separated participants receiving benefits .....		<b>6b</b>	<b>161</b>
<b>c</b> Other retired or separated participants entitled to future benefits .....		<b>6c</b>	<b>97</b>
<b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....		<b>6d</b>	<b>501</b>
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....		<b>6e</b>	<b>41</b>
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....		<b>6f</b>	<b>542</b>
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....		<b>6g</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....		<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		<b>7</b>	<b>57</b>

**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:

<b>9a</b> Plan funding arrangement (check all that apply)		<b>9b</b> Plan benefit arrangement (check all that apply)	
(1) <input type="checkbox"/> Insurance	(1) <input 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
(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
(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**

- (1)  **R** (Retirement Plan Information)
- (2)  **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)  **H** (Financial Information)
- (2)  **I** (Financial Information - Small Plan)
- (3)  **A** (Insurance Information)
- (4)  **C** (Service Provider Information)
- (5)  **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 2020 Form M-1 annual report. If the plan was not required to file the 2020 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 \_\_\_\_\_

<b>SCHEDULE C (Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>u File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2020</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2020 or fiscal plan year beginning **04/01/2020** and ending **03/31/2021**

<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN) <b>u</b>	<b>001</b>
<b>Boston Plasterers' &amp; Cement Masons' Union Local</b>		
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (EIN)	
<b>BOT-Boston Plasterers&amp;Cement Mason</b>	<b>04-6127786</b>	

**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		
<b>SEI TRUST COMPANY</b>		<b>06-1271230</b>
<b>1 FREEDOM VALLEY DRIVE</b>		
<b>OAKS</b>	<b>PA</b>	<b>19456</b>
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation		
<b>ARTISAN PARTNERS LTD PNSHP</b>		<b>39-1807188</b>
<b>1 FREEDOM VALLEY DRIVE</b>		
<b>OAKS</b>	<b>PA</b>	<b>19456</b>
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation		
<b>ALLIANZ GLOBAL INVESTORS LLC</b>		<b>02-0781030</b>
<b>555 MISSION STREET</b>		
<b>SAN FRANCISCO</b>	<b>CA</b>	<b>94105</b>
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation		
<b>BANK OF NEW YORK MELLON</b>		<b>25-6078093</b>
<b>50 FREMONT ST SUITE 3900</b>		
<b>NEW YORK</b>	<b>NY</b>	<b>10105</b>

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

**PIMCO 33-0629048**  
**650 NEWPORT CENTER DRIVE**  
**NEWPORT BEACH CA 92660**

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

**LOOMIS SAYLES FIXED INCOME FUND 04-3219175**  
**PO BOX 219594**  
**KANSAS CITY MO 64121**

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

**VANGUARD 500 INDEX ADMIRAL FUND 23-1945930**  
**PO BOX 2900**  
**VALLEY FORGE PA 19482**

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

**BOSTON TRUST WALDEN COMPANY 04-2273811**  
**ONE BEACON STREET**  
**BOSTON MA 02108**

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

**PNC REALTY INV/AFL-CIO BIT 22-1146430**  
**800 17TH STREET NW 12TH FLOOR**  
**WASHINGTON DC 20006**

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

**VANGUARD INFLATION PROTECTION SEC 23-1945930**  
**PO BOX 2900**  
**VALLEY FORGE PA 19482**

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

**NEUBERGER BERMAN INVESTMENT ADVISER 02-0654486**  
**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**

**LAZARD ASSET MANAGEMENT LLC 27-4311229**  
**30 ROCKEFELLER PLAZA**  
**NEW YORK NY 10112**

**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)

**MELLON CAPITAL MANAGEMENT** **25-6078093**  
**201 WASHINGTON STREET**  
**BOSTON** **MA 02108**

(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	N/A	21861	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

**CAMPBELL DEVASTO & ASSOC LLP CPAS** **04-2779892**  
**175 DERBY STREET SUITE 2**  
**HINGHAM** **MA 02043**

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	N/A	11288	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)

**CBIZ SAVITZ** **26-1371674**  
**75 SECOND AVENUE STE 605**  
**NEEDHAM** **MA 02494**

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	N/A	28910	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)

**KRAKOW & SOURIS LLC** **04-3363718**  
**225 FRIEND STREET**  
**BOSTON** **MA 02114**

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	N/A	15125	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)

**NEW ENGLAND PENSION CONSULTANTS** **04-2927339**  
**ONE MAIN STREET**  
**CAMBRIDGE** **MA 02142**

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	N/A	25000	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)

**ISSI** **23-2182079**  
**TWO EXECUTIVE CAMPUS #400**  
**CHERRY HILL** **NJ 08002**

(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?
15	N/A	15595	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)

**JP MORGAN CHASE BANK NA** **13-4994650**  
**500 STANTON CHRISTIANA RD**  
**NEWARK** **DE 19713**

(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?
24 27 28	N/A	7449	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

**CHRISTOPHER BROUSAIDES** **04-6127786**  
**7 FREDERIKA STREET**  
**BOSTON** **MA 02124**

(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?
30	N/A	34098	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)

**ANCHOR CAPITAL ADVISORS, INC.** **20-4669888**  
**ONE POST OFFICE SQUARE**  
**BOSTON** **MA 02108**

(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?
68 71 51	NONE	15373	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	477	Yes <input type="checkbox"/> No <input checked="" 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)

**GAIL MILLS** **04-6127786**  
**7 FREDERIKA STREET**  
**BOSTON** **MA 02124**

(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?
30	N/A	22908	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)

**CHRISTOPHER TYLER** **04-6127786**  
**7 FREDERIKA STREET**  
**BOSTON** **MA 02124**

(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?
30	N/A	15919	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)

**EATON VANCE TRUST COMPANY** **32-0225130**  
**2 INTERNATIONAL PLACE**  
**BOSTON** **MA 02110**

(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	N/A	5654	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.

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> 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.

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

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>SCHEDULE D</b> <b>(Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration	<b>DFE/Participating Plan Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>u File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2020</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2020 or fiscal plan year beginning **04/01/2020** and ending **03/31/2021**

<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN) <b>u</b>	<b>001</b>
<b>Boston Plasterers' &amp; Cement Masons' Union Local</b>		

<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (EIN)
<b>BOT-Boston Plasterers&amp;Cement Mason</b>	<b>04-6127786</b>

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

<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <b>EB DV DYNAMIC GROWTH FUND</b>		
<b>b</b> Name of sponsor of entity listed in (a): <b>THE BANK OF NEW YORK MELLON</b>		
<b>c</b> EIN-PN <b>25-6078093 166</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>2640502</b>

<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <b>ARTISAN INTERNATIONAL GROWTH TRUST</b>		
<b>b</b> Name of sponsor of entity listed in (a): <b>ARTISAN MULTIPLE INVESTMENT TRUST</b>		
<b>c</b> EIN-PN <b>26-3299719 002</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>4319037</b>

<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <b>AFL-CIO BUILDING INVESTMENT TRUST</b>		
<b>b</b> Name of sponsor of entity listed in (a): <b>PNC BANK</b>		
<b>c</b> EIN-PN <b>22-1146430 001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>567169</b>

<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <b>BOSTON TRUST SMALL CAP RETIREMENT FUND</b>		
<b>b</b> Name of sponsor of entity listed in (a): <b>BOSTON TRUST WALDEN COMPANY</b>		
<b>c</b> EIN-PN <b>04-2273811 001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>2989318</b>

<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <b>LAZARD EMERGING MARKET TOTAL RETURN FUND LP</b>		
<b>b</b> Name of sponsor of entity listed in (a): <b>LAZARD ASSET MANAGEMENT LLC</b>		
<b>c</b> EIN-PN <b>27-4311229 001</b>	<b>d</b> Entity code <b>E</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>1548691</b>

<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)





**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

**2020**

**This Form is Open to Public Inspection**

For calendar plan year 2020 or fiscal plan year beginning **04/01/2020** and ending **03/31/2021**

<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN)	001
<b>Boston Plasterers' &amp; Cement Masons' Union Local</b>		
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (EIN)	
<b>BOT-Boston Plasterers&amp;Cement Mason</b>	<b>04-6127786</b>	

**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.

<b>Assets</b>	<b>(a)</b> Beginning of Year	<b>(b)</b> End of Year
<b>a</b> Total noninterest-bearing cash	<b>1a</b>	
<b>b</b> Receivables (less allowance for doubtful accounts):		
<b>(1)</b> Employer contributions	<b>1b(1)</b> 483,042	547,844
<b>(2)</b> Participant contributions	<b>1b(2)</b>	
<b>(3)</b> Other	<b>1b(3)</b> 111,255	16,455
<b>c</b> General investments:		
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit)	<b>1c(1)</b> 1,103,098	756,646
<b>(2)</b> U.S. Government securities	<b>1c(2)</b> 201,201	
<b>(3)</b> Corporate debt instruments (other than employer securities):		
<b>(A)</b> Preferred	<b>1c(3)(A)</b>	
<b>(B)</b> All other	<b>1c(3)(B)</b> 1,303,869	1,610,248
<b>(4)</b> Corporate stocks (other than employer securities):		
<b>(A)</b> Preferred	<b>1c(4)(A)</b>	
<b>(B)</b> Common	<b>1c(4)(B)</b>	
<b>(5)</b> Partnership/joint venture interests	<b>1c(5)</b> 1,510,297	
<b>(6)</b> Real estate (other than employer real property)	<b>1c(6)</b> 752,925	765,831
<b>(7)</b> Loans (other than to participants)	<b>1c(7)</b>	
<b>(8)</b> Participant loans	<b>1c(8)</b>	
<b>(9)</b> Value of interest in common/collective trusts	<b>1c(9)</b> 9,884,968	10,516,026
<b>(10)</b> Value of interest in pooled separate accounts	<b>1c(10)</b>	
<b>(11)</b> Value of interest in master trust investment accounts	<b>1c(11)</b>	
<b>(12)</b> Value of interest in 103-12 investment entities	<b>1c(12)</b> 0	1,548,691
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds)	<b>1c(13)</b> 12,913,661	23,027,627
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts)	<b>1c(14)</b>	
<b>(15)</b> Other	<b>1c(15)</b>	



	(a) Beginning of Year	(b) End of Year
<b>1d</b> Employer-related investments:		
<b>(1)</b> Employer securities	<b>1d(1)</b>	
<b>(2)</b> Employer real property	<b>1d(2)</b>	
<b>e</b> Buildings and other property used in plan operation	<b>1e</b>	
<b>f</b> Total assets (add all amounts in lines 1a through 1e)	<b>1f</b>	<b>28,264,316</b>
<b>Liabilities</b>		
<b>g</b> Benefit claims payable	<b>1g</b>	
<b>h</b> Operating payables	<b>1h</b>	<b>68,318</b>
<b>i</b> Acquisition indebtedness	<b>1i</b>	
<b>j</b> Other liabilities	<b>1j</b>	
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j)	<b>1k</b>	<b>68,318</b>
<b>Net Assets</b>		
<b>l</b> Net assets (subtract line 1k from line 1f)	<b>1l</b>	<b>28,195,998</b>

**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
<b>a Contributions:</b>		
<b>(1)</b> Received or receivable in cash from: <b>(A)</b> Employers	<b>2a(1)(A)</b>	<b>5,343,238</b>
<b>(B)</b> Participants	<b>2a(1)(B)</b>	
<b>(C)</b> Others (including rollovers)	<b>2a(1)(C)</b>	
<b>(2)</b> Noncash contributions	<b>2a(2)</b>	
<b>(3)</b> Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b>	<b>2a(3)</b>	<b>5,343,238</b>
<b>b Earnings on investments:</b>		
<b>(1)</b> Interest:		
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit)	<b>2b(1)(A)</b>	<b>4,106</b>
<b>(B)</b> U.S. Government securities	<b>2b(1)(B)</b>	<b>2,375</b>
<b>(C)</b> Corporate debt instruments	<b>2b(1)(C)</b>	<b>32,346</b>
<b>(D)</b> Loans (other than to participants)	<b>2b(1)(D)</b>	
<b>(E)</b> Participant loans	<b>2b(1)(E)</b>	
<b>(F)</b> Other	<b>2b(1)(F)</b>	<b>2,754</b>
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b>	<b>2b(1)(G)</b>	<b>41,581</b>
<b>(2)</b> Dividends: <b>(A)</b> Preferred stock	<b>2b(2)(A)</b>	
<b>(B)</b> Common stock	<b>2b(2)(B)</b>	
<b>(C)</b> Registered investment company shares (e.g. mutual funds)	<b>2b(2)(C)</b>	<b>613,523</b>
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b>	<b>2b(2)(D)</b>	<b>613,523</b>
<b>(3)</b> Rents	<b>2b(3)</b>	
<b>(4)</b> Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds	<b>2b(4)(A)</b>	<b>2,312,107</b>
<b>(B)</b> Aggregate carrying amount (see instructions)	<b>2b(4)(B)</b>	<b>2,843,213</b>
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result	<b>2b(4)(C)</b>	<b>-531,106</b>
<b>(5)</b> Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate	<b>2b(5)(A)</b>	<b>12,906</b>
<b>(B)</b> Other	<b>2b(5)(B)</b>	<b>592,994</b>
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b>	<b>2b(5)(C)</b>	<b>605,900</b>

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	3,365,231
(7) Net investment gain (loss) from pooled separate accounts	2b(7)	
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)	4,662,993
c Other income	2c	69,402
d Total income. Add all <b>income</b> amounts in column (b) and enter total	2d	14,170,762

**Expenses**

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	3,291,684
(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)	3,291,684
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)	55,778
(2) Contract administrator fees	2i(2)	
(3) Investment advisory and management fees	2i(3)	76,932
(4) Other	2i(4)	243,241
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)	375,951
j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total	2j	3,667,635

**Net Income and Reconciliation**

k Net income (loss). Subtract line 2j from line 2d	2k	10,503,127
l Transfers of assets:		
(1) To this plan	2l(1)	
(2) From this plan	2l(2)	

**Part III Accountant's Opinion**

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

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1)  Unqualified (2)  Qualified (3)  Disclaimer (4)  Adverse

b 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: **Campbell DeVasto & Associates, CPA'** (2) EIN: **04-2779892**

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:

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.)

	Yes	No	Amount
4a		X	

	Yes	No	Amount
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>4b</b>		X	
<b>c</b> 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.)		X	
<b>4c</b>		X	
<b>d</b> 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.)		X	
<b>4d</b>		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		500000
<b>4e</b>	X		500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>4f</b>		X	
<b>g</b> 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?	X		12830549
<b>4g</b>	X		12830549
<b>h</b> 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?		X	
<b>4h</b>		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>4i</b>	X		
<b>j</b> 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.)	X		
<b>4j</b>	X		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>4k</b>		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>4l</b>		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>4m</b>		X	
<b>n</b> 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.			
<b>4n</b>			

**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 **4343222** \_\_\_\_\_.

**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

**2020**

**This Form is Open to Public  
Inspection**

For calendar plan year 2020 or fiscal plan year beginning **04/01/2020** and ending **03/31/2021**

▶ **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.

<b>A</b> Name of plan  <b>Boston Plasterers' &amp; Cement Masons' Union Local</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>001</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF  <b>BOT-Boston Plasterers&amp;Cement Mason</b>		<b>D</b> Employer Identification Number (EIN)  <b>04-6127786</b>

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

**1a** Enter the valuation date: Month **04** Day **01** Year **2020**

**b** Assets

(1) Current value of assets .....

**1b(1)** **28,195,998**

(2) Actuarial value of assets for funding standard account .....

**1b(2)** **33,627,652**

**c** (1) Accrued liability for plan using immediate gain methods .....

**1c(1)** **41,554,287**

(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)** **41,554,287**

**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)** **80,214,456**

(b) Expected increase in current liability due to benefits accruing during the plan year .....

**1d(2)(b)** **2,325,557**

(c) Expected release from "RPA '94" current liability for the plan year .....

**1d(2)(c)** **3,292,587**

(3) Expected plan disbursements for the plan year .....

**1d(3)** **3,592,584**

**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.

<b>SIGN HERE</b>	Signature of actuary <b>HAL S. TEPFER</b>	Date <b>10/21/2021</b>
	Type or print name of actuary <b>CBIZ RETIREMENT PLAN SERVICES</b>	Most recent enrollment number <b>617-454-1099</b>
	Firm name <b>75 SECOND AVENUE, SUITE 605</b>	Telephone number (including area code)
	<b>NEEDHAM MA 02464</b>	
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:

<b>a</b> Current value of assets (see instructions) .....	<b>2a</b>	<b>28,195,998</b>
<b>b</b> "RPA '94" current liability/participant count breakdown:	<b>(1) Number of participants</b>	<b>(2) Current liability</b>
<b>(1)</b> For retired participants and beneficiaries receiving payment .....	<b>198</b>	<b>44,236,487</b>
<b>(2)</b> For terminated vested participants .....	<b>95</b>	<b>10,841,751</b>
<b>(3)</b> For active participants:		
<b>(a)</b> Non-vested benefits .....		<b>2,633,081</b>
<b>(b)</b> Vested benefits .....		<b>22,503,137</b>
<b>(c)</b> Total active .....	<b>255</b>	<b>25,136,218</b>
<b>(4)</b> Total .....	<b>548</b>	<b>80,214,456</b>
<b>c</b> If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage .....	<b>2c</b>	<b>35.15 %</b>

**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
09/30/2002	4795394	0			
04/01/2021	547844	0			
<b>Totals u</b>			<b>3(b)</b>	<b>5343238</b>	<b>3(c)</b>
					<b>0</b>

**4** Information on plan status:

<b>a</b> Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)) .....	<b>4a</b>	<b>80.9 %</b>
<b>b</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 .....	<b>4b</b>	<b>N</b>
<b>c</b> Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>d</b> If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>e</b> If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date .....	<b>4e</b>	
<b>f</b> 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 .....	<b>4f</b>	<input type="checkbox"/>

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

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

<b>j</b> If box h is checked, enter period of use of shortfall method .....	<b>5j</b>	<b>16</b>
<b>k</b> Has a change been made in funding method for this plan year? .....		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>l</b> If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>m</b> 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 .....	<b>5m</b>	

**6 Checklist of certain actuarial assumptions:**

<b>a</b> Interest rate for "RPA '94" current liability .....	<b>6a</b>	<b>2.83 %</b>
<b>b</b> Rates specified in insurance or annuity contracts .....	Pre-retirement	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
<b>c</b> Mortality table code for valuation purposes:		
<b>(1)</b> Males .....	<b>6c(1)</b>	<b>11P</b>
<b>(2)</b> Females .....	<b>6c(2)</b>	<b>11FP</b>
<b>d</b> Valuation liability interest rate .....	<b>6d</b>	<b>8.00 %</b>
<b>e</b> Expense loading .....	<b>6e</b>	<b>41.4 %</b>
<b>f</b> Salary scale .....	<b>6f</b>	<input checked="" type="checkbox"/> N/A
<b>g</b> Estimated investment return on actuarial value of assets for year ending on the valuation date .....	<b>6g</b>	<b>2.1 %</b>
<b>h</b> Estimated investment return on current value of assets for year ending on the valuation date .....	<b>6h</b>	<b>-11.4 %</b>

**7 New amortization bases established in the current plan year:**

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
<b>1</b>	<b>1880368</b>	<b>203410</b>
<b>2</b>	<b>-234141</b>	<b>-25328</b>

**8 Miscellaneous information:**

<b>a</b> 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 .....	<b>8a</b>	
<b>b(1)</b> Is the plan required to provide a projection of expected benefit payments? (See the instructions.) If "Yes," attach a schedule .....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>b(2)</b> Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule .....		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>c</b> Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code? .....		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>d</b> If line c is "Yes," provide the following additional information:		
<b>(1)</b> Was an extension granted automatic approval under section 431(d)(1) of the Code? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(2)</b> If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended .....	<b>8d(2)</b>	
<b>(3)</b> Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(4)</b> 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)) .....	<b>8d(4)</b>	
<b>(5)</b> If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension .....	<b>8d(5)</b>	
<b>(6)</b> If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>e</b> 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) .....	<b>8e</b>	<b>66987</b>

**9 Funding standard account statement for this plan year:**

**Charges to funding standard account:**

<b>a</b> Prior year funding deficiency, if any .....	<b>9a</b>	<b>0</b>
<b>b</b> Employer's normal cost for plan year as of valuation date .....	<b>9b</b>	<b>1002740</b>
<b>c</b> Amortization charges as of valuation date:	Outstanding balance	
<b>(1)</b> All bases except funding waivers and certain bases for which the amortization period has been extended .....	<b>9c(1)</b>	<b>16737928</b>
<b>(2)</b> Funding waivers .....	<b>9c(2)</b>	<b>2265208</b>
<b>(3)</b> Certain bases for which the amortization period has been extended .....	<b>9c(3)</b>	
<b>d</b> Interest as applicable on lines 9a, 9b, and 9c .....	<b>9d</b>	<b>261436</b>
<b>e</b> Total charges. Add lines 9a through 9d .....	<b>9e</b>	<b>3529384</b>

**Credits to funding standard account:**

<b>f</b> Prior year credit balance, if any .....	<b>9f</b>	<b>4510503</b>
<b>g</b> Employer contributions. Total from column (b) of line 3 .....	<b>9g</b>	<b>5343238</b>
Outstanding balance		
<b>h</b> Amortization credits as of valuation date .....	<b>9h</b>	<b>4300790</b>
<b>i</b> Interest as applicable to end of plan year on lines 9f, 9g, and 9h .....	<b>9i</b>	<b>510377</b>
		<b>590321</b>

**j Full funding limitation (FFL) and credits:**

<b>(1)</b> ERISA FFL (accrued liability FFL) .....	<b>9j(1)</b>	<b>20405613</b>
<b>(2)</b> "RPA '94" override (90% current liability FFL) .....	<b>9j(2)</b>	<b>40813472</b>

<b>(3)</b> FFL credit .....	<b>9j(3)</b>	
<b>k (1)</b> Waived funding deficiency .....	<b>9k(1)</b>	
<b>(2)</b> Other credits .....	<b>9k(2)</b>	
<b>l</b> Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2) .....	<b>9l</b>	<b>10954439</b>
<b>m</b> Credit balance: If line 9l is greater than line 9e, enter the difference .....	<b>9m</b>	<b>7425055</b>
<b>n</b> Funding deficiency: If line 9e is greater than line 9l, enter the difference .....	<b>9n</b>	

**9 o Current year's accumulated reconciliation account:**

<b>(1)</b> Due to waived funding deficiency accumulated prior to the 2020 plan year .....	<b>9o(1)</b>	
<b>(2)</b> Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:		
<b>(a)</b> Reconciliation outstanding balance as of valuation date .....	<b>9o(2)(a)</b>	
<b>(b)</b> Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)) .....	<b>9o(2)(b)</b>	<b>0</b>
<b>(3)</b> Total as of valuation date .....	<b>9o(3)</b>	

**10** Contribution necessary to avoid an accumulated funding deficiency. (See instructions.) ..... **10** **0**

**11** Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions .....  Yes  No

<b>SCHEDULE R (Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Retirement Plan Information</b>  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).  <b>u File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2020</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2020 or fiscal plan year beginning **04/01/2020** and ending **03/31/2021**

<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN) <b>u</b>	<b>001</b>
<b>Boston Plasterers' &amp; Cement Masons' Union Local</b>		
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (EIN)	
<b>BOT-Boston Plasterers&amp;Cement Mason</b>		
<b>04-6127786</b>		

**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 0

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

**4** Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?  Yes  No  N/A  
**If the plan is a defined benefit plan, go to line 8.**

**5** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month \_\_\_ Day \_\_\_ Year \_\_\_\_  
**If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.**

<b>6 a</b> Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....	<b>6a</b>	
<b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....	<b>6b</b>	
<b>c</b> 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) .....	<b>6c</b>	

**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 **S & F CONCRETE**

**b** EIN **04-2439090**

**c** Dollar amount contributed by employer **1050545**

**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 **06** Day **30** Year **2021**

**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) **15.49**

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

**a** Name of contributing employer **MARGUERITE CONCRETE**

**b** EIN **04-3035873**

**c** Dollar amount contributed by employer **642776**

**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 **06** Day **30** Year **2021**

**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) **15.49**

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

**a** Name of contributing employer **EAST COAST FIREPROOFING**

**b** EIN **04-2693948**

**c** Dollar amount contributed by employer **562347**

**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 **06** Day **30** Year **2021**

**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) **15.49**

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

**a** Name of contributing employer **G & C CONCRETE**

**b** EIN **04-3041248**

**c** Dollar amount contributed by employer **524648**

**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 **06** Day **30** Year **2021**

**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) **15.49**

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

**a** Name of contributing employer **MARSHALL J. L. & SONS, INC.**

**b** EIN **05-0178105**

**c** Dollar amount contributed by employer **446933**

**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 **06** Day **30** Year **2021**

**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) **15.49**

(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:  last contributing employer  alternative  reasonable approximation (see instructions for required attachment)

**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)

**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)

<b>14a</b>		<b>0</b>
<b>14b</b>		<b>0</b>
<b>14c</b>		<b>0</b>

**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

**b** The corresponding number for the second preceding plan year

<b>15a</b>		<b>0.00</b>
<b>15b</b>		<b>0.00</b>

**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

**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

<b>16a</b>		<b>0</b>
<b>16b</b>		

**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: \_\_\_\_\_% Investment-Grade Debt: \_\_\_\_\_% High-Yield Debt: \_\_\_\_\_% Real Estate: \_\_\_\_\_% Other: \_\_\_\_\_%

**b** Provide the average duration of the combined investment-grade and high-yield debt:  
 0-3 years  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  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****2020**For calendar year 2020, or tax year beginning **04/01/2020**, and ending **03/31/2021**

Plan name <b>Boston Plasterers' &amp; Cement Masons' Union Local</b>		Three-digit plan number <b>001</b>
Sponsor name <b>BOT-Boston Plasterers&amp;Cement Mason</b>		Employer identification number <b>04-6127786</b>
<b>9 Funding standard account statement for this plan year:</b> <b>Charges to funding standard acct.: ALL EMPLOYERS</b>		
a	Prior year funding deficiency, if any .....	9a <b>0</b>
b	Employer's normal cost for plan year as of valuation date .....	9b <b>1,002,740</b>
c Amortization charges as of valuation date:		<b>Outstanding Balance</b>
(1)	All bases except funding waivers .....	c(1) <b>2,265,208</b>
(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 <b>261,436</b>
e	Total charges. Add lines 9a through 9d .....	9e <b>3,529,384</b>
<b>Credits to funding standard account:</b>		
f	Prior year credit balance, if any .....	9f <b>4,510,503</b>
g	Employer contributions. Total from column (b) of line 3 .....	9g
		<b>Outstanding Balance</b>
h	Amortization credits as of valuation date .....	9h <b>510,377</b>
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h .....	9i <b>590,321</b>
j Full funding limitation (FFL) and credits		
(1)	ERISA FFL (accrued liability FFL) .....	j(1) <b>20,405,613</b>
(2)	"RPA '94" override (90% current liability FFL) .....	j(2) <b>40,813,472</b>
(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 <b>5,611,201</b>
m	Credit balance: If line 9l is greater than line 9e, enter the difference .....	9m <b>2,081,817</b>
n	Funding deficiency: If line 9e is greater than line 9l, enter the difference .....	9n
<b>Reconciliation account:</b>		
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)

04-6127786

**Federal Statements**

FYE: 3/31/2021

**Boston Plasterers' & Cement Masons' Union Local****Plan: 001****Statement 1 - Form 5500, Schedule H, Line 2c - Other Income**

<u>Description</u>	<u>Amount</u>
COLLECTIVE TRUST DIVIDENDS	\$ 13,469
OTHER REIMBURSEMENTS	55,933
Total	<u>\$ 69,402</u>

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

<u>Description</u>	<u>Amount</u>
COLLECTION EXPENSE	\$ 41,042
COMPUTER EXPENSE	16,741
FIDUCIARY LIABILITY	7,201
EMPLOYEE BENEFITS	35,867
INSURANCE	17,114
INTERNATIONAL FOUNDATION	347
INTERNATIONAL PENSION	14,353
MEETING EXPENSE	509
OFFICE EXPENSE	2,300
PAYROLL TAX EXPENSE	6,033
POSTAGE	4,131
RENT EXPENSE	13,685
SALARIES	72,068
TELEPHONE	2,055
UTILITIES	983
FUND WAGE/BENEFIT REIM ADMIN	5,663
REPAIRS AND MAINTENANCE	3,149
Total	<u>\$ 243,241</u>

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

<u>Party in Interest</u>	<u>Identity</u>	<u>Description</u>	<u>Cost</u>	<u>Current Value</u>
	see financial report		\$	\$

04-6127786

**Federal Statements**

FYE: 3/31/2021

**Boston Plasterers' & Cement Masons' Union Local  
Plan: 001****Statement 4 - Schedule H, Line 4j - Schedule of Reportable Transactions (5%)**

<u>Name</u>		<u>Purchase Price</u>	<u>Selling Price</u>	<u>Lease Rental</u>	<u>Expenses</u>	<u>Cost of Asset</u>	<u>Current Value</u>	<u>Net Gain or Loss</u>
<u>Description</u>								
SEE FINANCIAL STATEMENT SCH		\$	\$	\$	\$	\$	\$	\$

**Federal Statements**

**Statement 5 - Schedule MB, line 11 - Justification for Change in Actuarial Assumptions**

Description

THE INTEREST RATE USED TO CALCULATE THE RPA CURRENT LIABILITY WAS DECREASED FROM 3.08% TO 2.83%. THE MORTALITY TABLE USED TO CALCULATE THE RPA CURRENT LIABILITY REFLECTS MORTALITY IMPROVEMENT SCALE MP-2018

THE ADMINISTRATIVE EXPENSE ASSUMPTION INCREASED FROM 280,000 TO 300,000.

04-6127786

**Federal Statements**

FYE: 3/31/2021

**Boston Plasterers' & Cement Masons' Union Local  
Plan: 001****Statement 6 - Schedule MB, line 9c - Schedule of funding Standard Account Bases**

Description		Initial Amount	Amortization Period	Outstanding Balance	Remaining Amortization Period	Amortization Amount	Amortization Basis
Date							
ALL EMPLOYERS							
3/31/20	\$	16,737,928		\$ 16,737,928		\$ 2,265,208	Other

**ALL EMPLOYERS****Statement 7 - Schedule MB, line 9h - Schedule of Funding Standard Account Bases**

Description	Date	Initial Amount	Amortization Period	Outstanding Balance	Remaining Amortization Period	Amortization Amount
AMORTIZATION CREDITS	3/31/20	\$		\$ 4,300,790	51	\$ 510,377
Total		\$	0	\$ 4,300,790		\$ 510,377

## Electronic Filing - PDF Attachment Report

Form **5500**For calendar year 2020, or tax year beginning **04/01/20**, and ending **03/31/21****2020**

Name

**BOT-Boston Plasterers&Cement Mason  
Union Local 534 Pension Fund**

Taxpayer Identification Number

**04-6127786**

Title	Attachment Source	Proforma
<b>Federal Attachments:</b>		
Schedule MB and SB: Active Participant Data	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB - Line 8b(2) - 2020 Schedule of Active Participant Data.pdf	No
Schedule MB and SB: Actuarial Assumptions Methods	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB - Line 6 - 2020 Statement of Actuarial Assumptions-Methods.pdf	No
Schedule MB and SB: Summary of Plan Provisions	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB - Line 6 - 2020 Summary of Plan Provisions.pdf	No
Schedule MB: Schedule of Funding Standard Account Bases	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB - Lines 9c and 9h - 2020 Schedule of FSA Bases.pdf	No
Schedule MB: Justification for Change in Actuarial Assumptions	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB - Line 11 - 2020 Justification for Change in Actuarial Assumptions.pdf	No
Schedule MB: Projection of Expected Benefit Payments	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB - Line 8b(1) - 2020 Expected Benefit Payments.pdf	No
Schedule MB: Actuarial Certification	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB Signed 2020 ACTUARYCERT.pdf	No
Schedule MB and SB: Statement by Enrolled Actuary	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB Signed 2020 ACTUARYSIGN.pdf	No
Signed Schedule MB or SB Image in PDF format	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\SCHEDULE MB\BPCM 534 Schedule MB - Signed 2020 Schedule MB.pdf	No
Schedule H and I: IQPA report (Accountant Opinion)	N:\CLIENT FILES\BPCM LOCAL 534\PENSION\2021\pffsigned2021.pdf	No
Schedule H: Schedule of Reportable Transactions	(automatically attached)	N/A



## Electronic Filing - PDF Attachment Report

Form **5500**For calendar year 2020, or tax year beginning **04/01/20**, and ending **03/31/21****2020**

Name

**BOT-Boston Plasterers&Cement Mason  
Union Local 534 Pension Fund**

Taxpayer Identification Number

**04-6127786**

Title	Attachment Source	Proforma
Schedule H: Schedule of Assets (Held at End of Year)	(automatically attached)	N/A