

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 2017 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2017 or fiscal plan year beginning <u>06/01/2017</u> and ending <u>05/31/2018</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) <input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ B This return/report is: <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months) C If the plan is a collectively-bargained plan, check here. <input checked="" type="checkbox"/> D Check box if filing under: <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information		
1a Name of plan <u>LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNI</u>	1b Three-digit plan number (PN) ▶	<u>001</u>	
	1c Effective date of plan <u>08/02/1963</u>		
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) <u>BOARD OF TRUSTEES LABORERS PENSION TRUST FUND FOR NOR CAL</u> <u>220 CAMPUS LANE</u> <u>FAIRFIELD, CA 94534-1498</u>	2b Employer Identification Number (EIN) <u>94-6277608</u>		
	2c Plan Sponsor's telephone number <u>707-864-2800</u>		
	2d Business code (see instructions) <u>236200</u>		

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	Filed with authorized/valid electronic signature.	03/05/2019	OSCAR DE LA TORRE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	03/05/2019	BILL KOPONEN
	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

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3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 36484
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) 17405
a(2) Total number of active participants at the end of the plan year	6a(2) 20118
b Retired or separated participants receiving benefits	6b 9737
c Other retired or separated participants entitled to future benefits	6c 7840
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 37695
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 1990
f Total. Add lines 6d and 6e	6f 39685
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7 1438

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

1B

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

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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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)** ☒ 1 **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 2017 Form M-1 annual report. If the plan was not required to file the 2017 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 2017 This Form is Open to Public Inspection
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For calendar plan year 2017 or fiscal plan year beginning 06/01/2017 and ending 05/31/2018	
A Name of plan LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNI	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES LABORERS PENSION TRUST FUND FOR NOR CAL	D Employer Identification Number (EIN) 94-6277608

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.
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1 Coverage Information:

(a) Name of insurance carrier THE UNION LABOR LIFE INSURANCE COMPANY
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(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	GA0251	39685	06/01/2017	05/31/2018

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 85039	(b) Total amount of fees paid 572665
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid ULLICO INVESTMENT COMPANY 8403 COLEVILLE ROAD SILVER SPRING, MD 20910
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
85039	572665	INVESTMENT MANAGEMENT FEES	6

(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	86057694

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
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 ▶	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)	
(2) Dividends and credits	7c(2)	
(3) Interest credited during the year	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)	7c(5)	
▶		
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)	7e(4)	
▶		
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE MB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection
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For calendar plan year 2017 or fiscal plan year beginning 06/01/2017 and ending 05/31/2018

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNI	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF BOARD OF TRUSTEES LABORERS PENSION TRUST FUND FOR NOR CAL	D Employer Identification Number (EIN) 94-6277608

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

1a Enter the valuation date: Month 06 Day 01 Year 2017

b Assets

(1) Current value of assets	1b(1)	2482945102
(2) Actuarial value of assets for funding standard account.....	1b(2)	2522234812
c (1) Accrued liability for plan using immediate gain methods	1c(1)	3026774728
(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)	3026774728
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)	5314701109
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	133376750
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	194491365
(3) Expected plan disbursements for the plan year	1d(3)	199491365

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	01/02/2019
Signature of actuary	Date
MARK HAMWEE, FSA, MAAA, EA	17-05829
Type or print name of actuary	Most recent enrollment number
SEGAL CONSULTING	415-263-8200
Firm name	Telephone number (including area code)
100 MONGOMERY STREET, SUITE 500, SAN FRANCISCO, CA 94104-4308	
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 ☐

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2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)	2a	2482945102
b "RPA '94" current liability/participant count breakdown:	(1) Number of participants	(2) Current liability
(1) For retired participants and beneficiaries receiving payment	11309	2511360519
(2) For terminated vested participants	7526	732464699
(3) For active participants:		
(a) Non-vested benefits		396730179
(b) Vested benefits		1674145712
(c) Total active	17399	2070875891
(4) Total	36234	5314701109
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	2c	46.72%

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
	331244228	0			
Totals ▶			3(b)	331244228	3(c) 0

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	4a	83.3%
b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If code is "N," go to line 5	4b	N
c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d 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	
e If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date	4e	
f If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here <input type="checkbox"/>	4f	

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

- a** ☐ Attained age normal
b ☐ Entry age normal
c ☒ Accrued benefit (unit credit)
d ☐ Aggregate
e ☐ Frozen initial liability
f ☐ Individual level premium
g ☐ Individual aggregate
h ☐ Shortfall
i ☐ Other (specify):

j If box h is checked, enter period of use of shortfall method	5j	
k Has a change been made in funding method for this plan year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
l 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	
m If line k is "Yes," and line l is "No," enter the date (MM-DD-YYYY) of the ruling letter (individual or class) approving the change in funding method	5m	

6 Checklist of certain actuarial assumptions:

a Interest rate for "RPA '94" current liability.....	6a		3.05%
	Pre-retirement		Post-retirement
b Rates specified in insurance or annuity contracts.....	<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
c Mortality table code for valuation purposes:			
(1) Males.....	6c(1)	13	13
(2) Females.....	6c(2)	13F	13F
d Valuation liability interest rate.....	6d	7.50%	7.50%
e Expense loading.....	6e	9.3% <input type="checkbox"/> N/A	% <input checked="" type="checkbox"/> N/A
f Salary scale.....	6f	% <input checked="" type="checkbox"/> N/A	
g Estimated investment return on actuarial value of assets for year ending on the valuation date.....	6g	7.6%	
h Estimated investment return on current value of assets for year ending on the valuation date.....	6h	11.6%	

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	-6067065	-639368

8 Miscellaneous information:

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

9 Funding standard account statement for this plan year:**Charges to funding standard account:**

a Prior year funding deficiency, if any.....	9a	0
b Employer's normal cost for plan year as of valuation date.....	9b	56444109
c Amortization charges as of valuation date:	Outstanding balance	
(1) All bases except funding waivers and certain bases for which the amortization period has been extended.....	9c(1)	934303348 141995359
(2) Funding waivers.....	9c(2)	0 0
(3) Certain bases for which the amortization period has been extended.....	9c(3)	0 0
d Interest as applicable on lines 9a, 9b, and 9c.....	9d	14882960
e Total charges. Add lines 9a through 9d.....	9e	213322428

Credits to funding standard account:

f	Prior year credit balance, if any	9f	342340571
g	Employer contributions. Total from column (b) of line 3	9g	331244228
		Outstanding balance	
h	Amortization credits as of valuation date.....	9h	87422861
i	Interest as applicable to end of plan year on lines 9f, 9g, and 9h	9i	38897248
j	Full funding limitation (FFL) and credits:		
(1)	ERISA FFL (accrued liability FFL)	9j(1)	1013310379
(2)	"RPA '94" override (90% current liability FFL)	9j(2)	2370660187
(3)	FFL credit	9j(3)	0
k	(1) Waived funding deficiency	9k(1)	0
	(2) Other credits	9k(2)	0
l	Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2).....	9l	723149349
m	Credit balance: If line 9l is greater than line 9e, enter the difference	9m	509826921
n	Funding deficiency: If line 9e is greater than line 9l, enter the difference.....	9n	
9o	Current year's accumulated reconciliation account:		
(1)	Due to waived funding deficiency accumulated prior to the 2017 plan year	9o(1)	0
(2)	Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:		
(a)	Reconciliation outstanding balance as of valuation date	9o(2)(a)	0
(b)	Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)).....	9o(2)(b)	0
(3)	Total as of valuation date	9o(3)	0
10	Contribution necessary to avoid an accumulated funding deficiency. (See instructions.)	10	
11	Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider 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
		2017
		This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning **06/01/2017** and ending **05/31/2018**

A Name of plan LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNI	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES LABORERS PENSION TRUST FUND FOR NOR CAL	D Employer Identification Number (EIN) 94-6277608

Part I	Service Provider Information (see instructions)
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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
LANDMARK EQUITY PARTNERS XIV, LP

06-1519082

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

13-3536050

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
GSO CAPITAL PARTNERS, LP

01-0899018

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
STRATEGIC VALUE SPECIAL SITUATIONS **485 LEXINGTON AVENUE**
NEW YORK, NY 10017

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

ORION MINE FINANCE FUND II, LP

81-1320456

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

TURNBRIDGE CAPITAL PARTNERS I

46-5712799

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

KOPERNIK GLOBAL INVESTORS, LLC

46-2760679

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

MERIT ENERGY COMPANY

75-2280562

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

ORBIMED ADVISORS, LLC

13-3976876

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

TRIATLANTIC CAPITAL MANAGEMENT LP

26-4600829

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

US FARMING REALTY TRUST

32-0360438

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

VERITAS CAPITAL FUND MANAGEMENT

13-4301934

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

EIF UNITED STATES POWER FUND IV, L.

04-3442917

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

OAK HILL ADVISORS LP

13-4077194

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

GEM REALTY FUND

80-0881501

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

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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)

LABORER'S FUND ADMINISTRATION

94-1563547

(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?
13 50	NONE	3732632	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)

MEKETA FIDUCIARY MANAGEMENT

5796 ARMADA DRIVE
CARLSBAD, CA 92008

(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 50	NONE	1085580	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)

MCMORGAN & COMPANY

52-2334338

(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 52 28	NONE	972743	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 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)

TDA INVESTMENT GROUP

94-2799130

(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?
28 64 51 52	NONE	896950	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 type="checkbox"/>

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

BLACKSTONE ALTERNATIVE ASSET MANAGE

13-3702086

(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?
28 51 52	NONE	523852	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 type="checkbox"/>

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

BOSTON PARTNERS

98-0202744

(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?
28 51 52	NONE	497504	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 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)

VOYA INVESTMENT TRUST COMPANY

06-1440627

(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?
28 51 52	NONE	443364	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 type="checkbox"/>

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

STATE STREET GLOBAL ADVISORS

04-1867445

(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?
28 51 52 99	NONE	387906	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 type="checkbox"/>

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

QUEST INVESTMENT INC.

98-0880854

(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?
28 51 52	NONE	309566	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 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)

ARTISAN PARTNER LTD PARTNERSHIP

30-0551775

(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?
28 51 52 68	NONE	306788	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 type="checkbox"/>

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

DIMENSION FUND ADVISORS

23-6819730

(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?
28 51	NONE	296088	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)

HARBORVEST PARTNERS

74-3130888

(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?
28 51 52	NONE	286223	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 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)

US BANK

31-0841368

(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?
19 51 52	NONE	284940	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 type="checkbox"/>

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

THE SEGAL COMPANY

94-1503999

(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 50	NONE	149153	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)

WEINBERG, ROGER & ROSENFELD

94-2458080

(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 50	NONE	96834	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)

BULLIVANT HOUSER BAILEY

93-1129534

(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 50	NONE	89433	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)

GOLDMAN SACHS FUND MANAGEMENT

13-3575636

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
51 28	NONE	78654	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)

CBRE

95-2743174

(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 50	NONE	54900	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)

LINDQUIST LLP

52-2385296

(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 50	NONE	46800	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)

PACIFIC PRINTING

26-4644580

(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?
36 50	NONE	40629	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)

INSTINET

150 CALIFORNIA STREET
SAN FRANCISCO, CA 94111

(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?
33 50	NONE	25086	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)

VERUS ADVISORY

91-1320111

(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?
17 50 27	NONE	16767	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)

PIMCO

33-0629048

(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?
28 51 52	NONE	9183	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 type="checkbox"/>

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

CREDIT SUISSE SECURITIES

650 CALIFORNIA STREET
SAN FRANCISCO, CA 94108

(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?
33 50	NONE	9104	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)

MERRILL, LYNCH, PIERCE, FENNER

ONE BRYANT PARK
NEW YORK, NY 10036

(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?
33 50	NONE	8040	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)

JP MORGAN SECURITIES

560 MISSION STREET
SAN FRANCISCO, CA 94105

(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?
33 50	NONE	6442	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)

ITGIUS31

175 SULLY TRAIL
PITTSFORD, NY 14534

(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?
33 50	NONE	6250	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)

LIQUIDNET, INC

1 SUTTER STREET
SAN FRANCISCO, CA 94104

(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?
33 50	NONE	5744	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)

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

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input 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
BLACKSTONE ALTERNATIVE ASSET MANAGE 13-3702086	28 51 52	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING INDIRECT COMPENSATION.
GOLDMAN SACHS FUND MANAGEMENT 13-3575636	28 51	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING INDIRECT COMPENSATION.
CBRE 95-2743174	27 50	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING INDIRECT COMPENSATION.
WARBURG PINCUS PRIVATE EQUITY 13-3536050	28 51	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING INDIRECT COMPENSATION.
CAITAL INTERNATIONAL PRIVATE EQUITY 1 MARKET STREET 2000 SAN FRANCISCO, CA 94105	28 51	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING INDIRECT COMPENSATION.
GSO CAPITAL PARTNERS, LP 345 PARK AVENUE NEW YORK, NY 10154	28 51	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING 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
SOUTHERN CROSS LATIN AMERICA FUND L 98-0518602	28 51	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING INDIRECT COMPENSATION.
WAUD CAPITAL PARTNERS LP 300 NORTH LASALLE STREET CHICAGO, IL 60654	28 51	SERVICE PROVIDER DID NOT RESPOND TO REQUEST FOR INFORMATION REGARDING INDIRECT COMPENSATION.

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	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 <div style="border: 1px solid black; padding: 5px; font-size: 1.2em; font-weight: bold;">2017</div> This Form is Open to Public Inspection.
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For calendar plan year 2017 or fiscal plan year beginning 06/01/2017 and ending 05/31/2018

A Name of plan <u>LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNI</u>	B Three-digit plan number (PN)	<u>001</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>BOARD OF TRUSTEES LABORERS PENSION TRUST FUND FOR NOR CAL</u>	D Employer Identification Number (EIN) <u>94-6277608</u>	

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)
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a Name of MTIA, CCT, PSA, or 103-12 IE: <u>THE SMALL CAP VALUE SUBTRUST</u>			
b Name of sponsor of entity listed in (a): <u>DFA GROUP TRUST</u>			
c EIN-PN <u>23-6819730-001</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>44815706</u>	
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>HIPEP VI CAYMAN PARTNERSHIP FUND LP</u>			
b Name of sponsor of entity listed in (a): <u>HARBOURVEST PARTNERS LLC</u>			
c EIN-PN <u>98-0582576-001</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>7413782</u>	
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>HARBOURVEST PARTNER IX CAYMAN CR O</u>			
b Name of sponsor of entity listed in (a): <u>HARBOURVEST PARTNERS LLC</u>			
c EIN-PN <u>75-3269994-001</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>8805141</u>	
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>PRIVATE EQUITY PARTNERS X-MGR LP</u>			
b Name of sponsor of entity listed in (a): <u>GOLDMAN SACHS PEP X ADVISORS LLC</u>			
c EIN-PN <u>26-2610183-001</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>11128544</u>	
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MSCI EAFE INDEX SL FUND</u>			
b Name of sponsor of entity listed in (a): <u>STATE STREET BANK & TRUST CO</u>			
c EIN-PN <u>04-0025081-240</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>274436248</u>	
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MSCI EMERGING MKTS INDEX SL COMMON</u>			
b Name of sponsor of entity listed in (a): <u>STATE STREET BANK & TRUST CO</u>			
c EIN-PN <u>04-3407623-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>60505027</u>	
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>US TIPS INDEX NL FUND</u>			
b Name of sponsor of entity listed in (a): <u>STATE STREET BANK & TRUST CO</u>			
c EIN-PN <u>04-0025081-152</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>184658279</u>	

a Name of MTIA, CCT, PSA, or 103-12 IE: **SSGA S&P FLAGSHIP SL FUND**

b Name of sponsor of entity listed in (a): **STATE STREET BANK & TRUST CO**

c EIN-PN 04-0025081-002	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 149623616
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a Name of MTIA, CCT, PSA, or 103-12 IE: **SEPARATE J ACCOUNT**

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

c EIN-PN 13-1423090-203	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 86057694
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a Name of MTIA, CCT, PSA, or 103-12 IE: **VOYA SENIOR LOAN TRUST FUND**

b Name of sponsor of entity listed in (a): **VOYA INVESTMENT TRUST CO**

c EIN-PN 06-1440627-045	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 113507321
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a Name of MTIA, CCT, PSA, or 103-12 IE: **SSGA US AGGREGATE BOND INDEX FUND**

b Name of sponsor of entity listed in (a): **STATE STREET BANK & TRUST CO**

c EIN-PN 04-0025081-070	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 203300987
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a Name of MTIA, CCT, PSA, or 103-12 IE: **SSGA US ST GOV CREDIT/BOND INDEX F**

b Name of sponsor of entity listed in (a): **STATE STREET BANK & TRUST CO**

c EIN-PN 27-6934633-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 65155292
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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)
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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)
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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)
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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)
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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)
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Part II Information on Participating Plans (to be completed by DFEs)

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

a Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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 2017 This Form is Open to Public Inspection
For calendar plan year 2017 or fiscal plan year beginning <u>06/01/2017</u> and ending <u>05/31/2018</u>		
A Name of plan <u>LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNI</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>BOARD OF TRUSTEES LABORERS PENSION TRUST FUND FOR NOR CAL</u>	D Employer Identification Number (EIN) <u>94-6277608</u>	

Part I	Asset and Liability Statement		(a) Beginning of Year	(b) End of Year
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	Total noninterest-bearing cash	1a	-2396130	-2113192
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions	1b(1)	26287585	33004511
	(2) Participant contributions	1b(2)		
	(3) Other.....	1b(3)	27236244	72972001
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	71664255	146166269
	(2) U.S. Government securities.....	1c(2)	101024675	111766461
	(3) Corporate debt instruments (other than employer securities):			
	(A) Preferred	1c(3)(A)		
	(B) All other.....	1c(3)(B)	170639728	158248017
	(4) Corporate stocks (other than employer securities):			
	(A) Preferred	1c(4)(A)		
	(B) Common	1c(4)(B)	347387929	111937853
	(5) Partnership/joint venture interests	1c(5)	168671278	321526917
	(6) Real estate (other than employer real property)	1c(6)	16666860	15795530
	(7) Loans (other than to participants)	1c(7)	3320448	3320448
	(8) Participant loans	1c(8)		
	(9) Value of interest in common/collective trusts.....	1c(9)	1005925669	1051186770
	(10) Value of interest in pooled separate accounts.....	1c(10)	83802283	86057694
	(11) Value of interest in master trust investment accounts	1c(11)		
	(12) Value of interest in 103-12 investment entities	1c(12)	98970648	72163173
	(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	115304935	207055626
	(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
	(15) Other	1c(15)	429958551	510923652

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	2664464958	2900011730

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h	1443544	1212869
i Acquisition indebtedness	1i		
j Other liabilities	1j	180076312	91371025
k Total liabilities (add all amounts in lines 1g through 1j)	1k	181519856	92583894

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	2482945102	2807427836
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Part II Income and Expense Statement

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

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	331244228	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		331244228
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	1344372	
(B) U.S. Government securities	2b(1)(B)	2866471	
(C) Corporate debt instruments	2b(1)(C)	7471237	
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	9852687	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		21534767
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	3832930	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	6221248	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		10054178
(3) Rents	2b(3)		901598
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	2595363560	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	2512110085	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		83253475
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	148907987	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		148907987

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		-67171958
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		2904819
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		-8273369
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		-1965476
c Other income.....	2c		240129
d Total income. Add all income amounts in column (b) and enter total.....	2d		521630378

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	182735275	
(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)		182735275
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)	792131	
(2) Contract administrator fees	2i(2)	3732632	
(3) Investment advisory and management fees	2i(3)	8628810	
(4) Other	2i(4)	1258796	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		14412369
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		197147644

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		324482734
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 Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? ☐ Yes ☒ No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: LINDQUIST LLP

(2) EIN: 52-2385296

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.).....

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.)

	Yes	No	Amount
4a		X	
4b		X	

	Yes	No	Amount
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.)		X	
4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
4d		X	
e Was this plan covered by a fidelity bond?	X		5000000
4e	X		5000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
4g		X	
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?		X	
4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	X		
4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
4k		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			
4n			

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

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

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

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? ☒ Yes ☐ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 4117315. (See instructions.)

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection.
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For calendar plan year 2017 or fiscal plan year beginning 06/01/2017 and ending 05/31/2018

A Name of plan <u>LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNI</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>BOARD OF TRUSTEES LABORERS PENSION TRUST FUND FOR NOR CAL</u>	D Employer Identification Number (EIN) <u>94-6277608</u>

Part I	Distributions
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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	<u>0</u>

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.)
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4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> N/A
If the plan is a defined benefit plan, go to line 8.			
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____ If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.			
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a		
b Enter the amount contributed by the employer to the plan for this plan year	6b		
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c		
If you completed line 6c, skip lines 8 and 9.			
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> N/A

Part III	Amendments
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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.	<input type="checkbox"/> Increase	<input type="checkbox"/> Decrease	<input type="checkbox"/> Both	<input checked="" type="checkbox"/> No
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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.
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10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11 a Does the ESOP hold any preferred stock?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

Schedule R (Form 5500) 2017
v. 170203

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

- 14** Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	14a	17577
b The plan year immediately preceding the current plan year	14b	17173
c The second preceding plan year	14c	17282

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

a The corresponding number for the plan year immediately preceding the current plan year	15a	1.02
b The corresponding number for the second preceding plan year	15b	1.02

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

a Enter the number of employers who withdrew during the preceding plan year	16a	0
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	

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

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

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

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

- a** Enter the percentage of plan assets held as:

Stock: 4.0% Investment-Grade Debt: 9.0% High-Yield Debt: 3.0% Real Estate: 1.0% Other: 83.0%

- 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):