

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210 - 0110
1210 - 0089

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**


- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instr.)
- a single-employer plan a DFE (specify) _____
- B** This return/report is: the first return/report the final return/report
- an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively bargained plan, check here
- D** Check box if filing under: Form 5558 automatic extension the DFVC program
- special extension (enter description)

Part II Basic Plan Information - enter all requested information

1a Name of plan SHEET METAL WORKERS' NATIONAL PENSION FUND	1b Three-digit plan number (PN) ▶ 001
	1c Effective date of plan 05/16/1966
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) BD OF TRUSTEES SHEET METAL WORKERS' NATIONAL PENSIO	2b Employer Identification Number (EIN) 52-6112463
	2c Plan Sponsor's telephone number (703) 739-7000
3180 FAIRVIEW PARK DRIVE SUITE 400 FALLS CHURCH VA 22042	2d Business code (see instructions) 238100

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

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

SIGN HERE		10/13/2021	JOSEPH SELLERS, JR.
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2020)
v. 200204

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	144,397
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)	62,816
a (2) Total number of active participants at the end of the plan year	6a(2)	61,565
b Retired or separated participants receiving benefits	6b	39,982
c Other retired or separated participants entitled to future benefits	6c	33,529
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	135,076
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	9,647
f Total. Add lines 6d and 6e	6f	144,723
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	3,832

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
1B 1E

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 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
--	--

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) <input checked="" type="checkbox"/> R (Retirement Plan Information) (2) <input checked="" type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> <u>3</u> A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
---	--

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

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

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

11c Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	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 2020 This Form is Open to Public Inspection
--	--	---

For calendar plan year 2020 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**

A Name of plan SHEET METAL WORKERS ' NATIONAL PENSION FUND	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES SHEET METAL WORKERS ' NATIONAL PENSIO		D Employer Identification Number (EIN) 52-6112463

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AETNA

(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
06-1067464	97101	GA 1433,1523		01/01/2020	12/31/2020

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end	4	136,330
5 Current value of plan's interest under this contract in separate accounts at year end	5	

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	6d	

Specify nature of costs ▶

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

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 A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	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 2020 This Form is Open to Public Inspection
--	--	---

For calendar plan year 2020 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**

A Name of plan SHEET METAL WORKERS ' NATIONAL PENSION FUND	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES SHEET METAL WORKERS ' NATIONAL PENSIO		D Employer Identification Number (EIN) 52-6112463

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0233346	65838	GAC 1022 ASSN 0	235	01/01/2020	12/31/2020

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	2,494,314

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs ▶

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	1,710,671
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits	7c(2)	
(3) Interest credited during the year	7c(3)	103,214
(4) Transferred from separate account	7c(4)	215,207
(5) Other (specify below)	7c(5)	6,223
▶ REALIZED CAP G/L, MKT VALUE ADJ		
(6) Total additions	7c(6)	324,644
d Total of balance and additions (add lines 7b and 7c(6))	7d	2,035,315
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	430,261
(2) Administration charge made by carrier	7e(2)	36,462
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)	7e(4)	
▶		
(5) Total deductions	7e(5)	466,723
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	1,568,592

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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 A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	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 2020 This Form is Open to Public Inspection
--	---	---

For calendar plan year 2020 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**

A Name of plan SHEET METAL WORKERS ' NATIONAL PENSION FUND	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES SHEET METAL WORKERS ' NATIONAL PENSIO		D Employer Identification Number (EIN) 52-6112463

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	GA00204		01/01/2020	12/31/2020

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end	4	655,203
5 Current value of plan's interest under this contract in separate accounts at year end	5	

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	6d	

Specify nature of costs ▶

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

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. ▶

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.	

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 2020 This Form is Open to Public Inspection.
---	--	--

For calendar plan year 2020 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**

A Name of plan SHEET METAL WORKERS' NATIONAL PENSION FUND	B Three-digit plan number (PN) ►	001
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES SHEET METAL WORKERS' NATIONAL PENSIO	D Employer Identification Number (EIN) 52-6112463	

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

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

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

c EIN-PN 20-1641876 001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 114,228,368.
---------------------------------------	-------------------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE: **COLLECTIVE SHORT TERM INVEST FUND**

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

c EIN-PN 13-6154008 003	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 134,711,216.
---------------------------------------	-------------------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE: **EB DV LARGE CAP GROWTH STOCK INDEX**

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

c EIN-PN 25-6078093 003	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 52,098,152.
---------------------------------------	-------------------------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: **EB DV LARGE CAP VALUE STOCK INDEX**

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

c EIN-PN 25-6078093 005	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 79,473,469.
---------------------------------------	-------------------------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: **EB DV EMERGING MARKETS INDEX**

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

c EIN-PN 25-6078093 189	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 137,578,165.
---------------------------------------	-------------------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE: **LEGAL & GENERAL COLLECTIVE TRUST S&**

b Name of sponsor of entity listed in (a): **RELIANCE TRUST COMPANY OF DELAWARE**

c EIN-PN 35-7085469 004	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 595,127,988.
---------------------------------------	-------------------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE: **LEGAL & GENERAL COLLECTIVE TRUST SP**

b Name of sponsor of entity listed in (a): **RELIANCE TRUST COMPANY OF DELAWARE**

c EIN-PN 35-7085469 005	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 867,790,866.
---------------------------------------	-------------------------------	---

For Paperwork Reduction Act Notice, see the Instructions for Form 5500. **Schedule D (Form 5500) 2020 v. 200204**

a Name of MTIA, CCT, PSA, or 103-12 IE: **LEGAL & GENERAL COLLECTIVE TRUST SP**

b Name of sponsor of entity listed in (a): **RELIANCE TRUST COMPANY OF DELAWARE**

c EIN-PN 35-7085469 009	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 180,150,637.
---------------------------------------	-------------------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE: **LEGAL & GENERAL COLLECTIVE TRUST MS**

b Name of sponsor of entity listed in (a): **RELIANCE TRUST COMPANY OF DELAWARE**

c EIN-PN 35-7085469 001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 268,704,824.
---------------------------------------	-------------------------------	---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2020 This Form is Open to Public Inspection
---	--	---

For calendar plan year 2020 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**

A Name of plan	B Three-digit plan number (PN) ►	001
SHEET METAL WORKERS' NATIONAL PENSION FUND		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
BD OF TRUSTEES SHEET METAL WORKERS' NATIONAL PENSIO		
		52-6112463

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	87,367,993	82,282,557
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	57,547,982	62,332,121
(2) Participant contributions		
(3) Other SEE STATEMENT 2	71,277,849	25,048,651
c General investments:		
(1) Interest-bearing cash (incl. money market accounts & certificates of deposit)	364,215,790	443,122,945
(2) U.S. Government securities	502,738,423	491,940,746
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred		
(B) All other	434,528,283	468,246,794
(4) Corporate stocks (other than employer securities):		
(A) Preferred		
(B) Common	915,688,235	1,439,501,594
(5) Partnership/joint venture interests	1,004,772,206	1,153,980,743
(6) Real estate (other than employer real property)		
(7) Loans (other than to participants)		
(8) Participant loans		
(9) Value of interest in common/collective trusts	2,413,296,949	2,429,863,685
(10) Value of interest in pooled separate accounts		
(11) Value of interest in master trust investment accounts		
(12) Value of interest in 103-12 investment entities		
(13) Value of interest in registered investment companies (e.g., mutual funds)	195,667,980	216,162,670
(14) Value of funds held in insurance co. general account (unallocated contracts)	178,660,862	181,931,703
(15) Other SEE STATEMENT 3		

		(a) Beginning of Year	(b) End of Year
1 d	Employer-related investments:		
	(1) Employer securities	1d(1)	
	(2) Employer real property	1d(2)	
e	Buildings and other property used in plan operation	1e	1,661
f	Total assets (add all amounts in lines 1a through 1e)	1f	6,225,764,213
Liabilities			
g	Benefit claims payable	1g	
h	Operating payables	1h	3,372,485
i	Acquisition indebtedness	1i	
j	Other liabilities	1j	427,341,106
	SEE STATEMENT 4		509,015,275
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	430,713,591
			511,375,970
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	5,795,050,622
			6,483,038,239

Part II Income and Expense Statement

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

		(a) Amount	(b) Total
Income			
a	Contributions:		
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	562,364,167
	(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)	562,364,167
b	Earnings on investments:		
	(1) Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	-9,466
	(B) U.S. Government securities	2b(1)(B)	10,433,679
	(C) Corporate debt instruments	2b(1)(C)	16,371,273
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans	2b(1)(E)	
	(F) Other	2b(1)(F)	10,451,284
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	37,246,770
	(2) Dividends: (A) Preferred stock	2b(2)(A)	123,750
	(B) Common stock	2b(2)(B)	17,657,606
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	1,786,798
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)	19,568,154
	(3) Rents	2b(3)	
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds ...	2b(4)(A)	269,460,239
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	216,606,740
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result ...	2b(4)(C)	52,853,499
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate ...	2b(5)(A)	
	(B) Other	2b(5)(B)	261,986,933
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	261,986,933

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	284,969,089
(7) Net investment gain (loss) from pooled separate accounts	2b(7)	
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)	20,403,507
c Other income SEE STATEMENT 5	2c	7,460,800
d Total income. Add all income amounts in column (b) and enter total	2d	1,246,852,919

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	531,713,982
(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)	531,713,982
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)	2,132,977
(2) Contract administrator fees	2i(2)	
(3) Investment advisory and management fees	2i(3)	12,248,944
(4) Other SEE STATEMENT 6	2i(4)	12,769,399
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)	27,151,320
j Total expenses. Add all expense amounts in column (b) and enter total	2j	558,865,302

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	687,987,617
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) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

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

c Enter the name and EIN of the accountant (or accounting firm) below:
 (1) Name: **CALIBRE CPA GROUP PLLC** (2) EIN: **47-0900880**

d The opinion of an independent qualified public accountant is **not attached** because:
 (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) ...		X	
4a		X	

	Yes	No	Amount
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)			
4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)			
4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)			
4d		X	
e Was this plan covered by a fidelity bond?	X		1,000,000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			
4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4g	X		1,155,923,118
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)			
4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)			
4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			
4k		X	
l Has the plan failed to provide any benefit when due under the plan?			
4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3			
4n		X	

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

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 4316124.

SCHEDULE MB (Form 5500) <small>Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	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 2020 This Form is Open to Public Inspection
---	--	---

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 , and ending 12/31/2020 ,

► **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	B Three-digit plan number (PN) ►	001
SHEET METAL WORKERS ' NATIONAL PENSION FUND		
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF	D Employer Identification Number (EIN)	
BD OF TRUSTEES SHEET METAL WORKERS ' NATIONAL PENSIO	52-6112463	

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

1 a Enter the valuation date: Month 01 Day 01 Year 2019

b Assets

(1) Current value of assets	1b(1)	5,782,976,579
(2) Actuarial value of assets for funding standard account	1b(2)	5,634,419,729
c (1) Accrued liability for plan using immediate gain methods	1c(1)	8,044,416,537
(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)	8,044,416,537
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)	15445499349
(b) Expected increase in current liability due to benefits accruing during the plan year	1d(2)(b)	250,450,974
(c) Expected release from "RPA '94" current liability for the plan year	1d(2)(c)	544,372,068
(3) Expected plan disbursements for the plan year	1d(3)	559,372,068

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	
Signature of actuary DANIEL V. CINER, MAAA Type or print name of actuary SEGAL CONSULTING Firm name 101 NORTH WACKER DRIVE, SUITE 500 CHICAGO IL 60606-1724 Address of the firm	Date 2005773 Most recent enrollment number 312-984-8500 Telephone number (including area code)

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

2 Operational information as of beginning of this plan year:

a Current value of assets (see instructions)	2a	5,794,474,602
b "RPA '94" current liability/participant count breakdown:	(1) Number of participants	(2) Current liability
(1) For retired participants and beneficiaries receiving payment	48,834	6,758,343,952
(2) For terminated vested participants	32,750	2,225,616,226
(3) For active participants:		
(a) Non-vested benefits		970,607,665
(b) Vested benefits		5,490,931,506
(c) Total active	62,816	6,461,539,171
(4) Total	144,400	15445499349
c If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage	2c	37.5200 %

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
06-30-2020	545,854,831				
06-30-2020	10,709,532				
Totals ▶			3(b)	556564363	3(c)

4 Information on plan status:

a Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3))	4a	70.00 %
b Enter code to indicate plan's status (see instructions for attachment of supporting evidence of plan's status). If entered code is "N," go to line 5	4b	E
c Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan?		<input checked="" 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	4f	

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

- | | | | |
|--|--|--|---|
| a <input type="checkbox"/> Attained age normal | b <input type="checkbox"/> Entry age normal | c <input checked="" type="checkbox"/> Accrued benefit (unit credit) | d <input type="checkbox"/> Aggregate |
| e <input type="checkbox"/> Frozen initial liability | f <input type="checkbox"/> Individual level premium | g <input type="checkbox"/> Individual aggregate | h <input type="checkbox"/> Shortfall |
| i <input type="checkbox"/> 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	2.95	%			
b	Rates specified in insurance or annuity contracts	Pre-retirement			Post-retirement		
		Yes	No	<input checked="" type="checkbox"/> N/A	Yes	No	<input checked="" type="checkbox"/> N/A
c	Mortality table code for valuation purposes:						
(1)	Males	6c(1)	13A	13A			
(2)	Females	6c(2)	13FA	13FA			
d	Valuation liability interest rate	6d	7.50	%	7.50		
e	Expense loading	6e	16.8	%	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			6.6	%	
h	Estimated investment return on current value of assets for year ending on the valuation date	6h			17.2	%	

7 New amortization bases established in the current plan year:

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	70,418,590	7,420,956
3	310,187	32,689

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 checked="" type="checkbox"/> Yes	<input 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 checked="" 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)	5
(3) Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code?	<input type="checkbox"/> Yes	<input checked="" 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	511,219,657

9 Funding standard account statement for this plan year:

Charges to funding standard account:

a Prior year funding deficiency, if any	9a	
b Employer's normal cost for plan year as of valuation date	9b	100,410,617
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)	4,405,421,044
(2) Funding waivers	9c(2)	586,918,602
(3) Certain bases for which the amortization period has been extended	9c(3)	
d Interest as applicable on lines 9a, 9b, and 9c	9d	51,549,691
e Total charges. Add lines 9a through 9d	9e	738,878,910

Credits to funding standard account:

f Prior year credit balance, if any	9f	597,481,991
g Employer contributions. Total from column (b) of line 3	9g	556,564,363
	Outstanding balance	
h Amortization credits as of valuation date	9h	1,397,942,245
i Interest as applicable to end of plan year on lines 9f, 9g, and 9h	9i	84,900,693

j Full funding limitation (FFL) and credits:		
(1) ERISA FFL (accrued liability FFL)	9j(1)	3,340,981,122
(2) "RPA '94" override (90% current liability FFL)	9j(2)	8,569,215,076
(3) FFL credit	9j(3)	
k (1) Waived funding deficiency	9k(1)	
(2) Other credits	9k(2)	
l Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2)	9l	1,495,192,128
m Credit balance: If line 9l is greater than line 9e, enter the difference	9m	756,313,218
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 2020 plan year	9o(1)	
(2) Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:		
(a) Reconciliation outstanding balance as of valuation date	9o(2)(a)	
(b) Reconciliation amount (line 9c(3) balance minus line 9o(2)(a))	9o(2)(b)	
(3) Total as of valuation date	9o(3)	

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 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 2020 This Form is Open to Public Inspection.
--	---	--

For calendar plan year 2020 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

A Name of plan SHEET METAL WORKERS ' NATIONAL PENSION FUND	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 BD OF TRUSTEES SHEET METAL WORKERS ' NATIONAL PENSIO	D Employer Identification Number (EIN)	52-6112463

Part I Distributions

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

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

1		0
---	--	---

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): 52-6112463 80-0709115

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		112
---	--	-----

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

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

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

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

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

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a	
b Enter the amount contributed by the employer to the plan for this plan year	6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c	

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

a Name of contributing employer _____

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

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

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

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

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

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

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input checked="" type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment)	14a	95
b The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	14b	47
c The second preceding plan year <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment).	14c	137

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	2.02
b The corresponding number for the second preceding plan year	15b	.69

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	15
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	15,727,921

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: 54.7 % Investment-Grade Debt: 16.4 % High-Yield Debt: 1.5 % Real Estate: 8.1 % Other: 19.4 %

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

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

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

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

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation _____

SCHEDULE C	OTHER SERVICE PROVIDER SERVICE CODES	STATEMENT 1
------------	--------------------------------------	-------------

NAME	SERVICE CODES
GRAYSTONE CONSULTING	27
GRAYSTONE CONSULTING	31
GRAYSTONE CONSULTING	33
GRAYSTONE CONSULTING	50
GRAYSTONE CONSULTING	70

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H	OTHER RECEIVABLES	STATEMENT 2
------------	-------------------	-------------

DESCRIPTION	BEGINNING	ENDING
ACCRUED INTEREST AND DIVIDENDS	7,104,153.	6,498,943.
RECEIVABLE FOR INVESTMENT SECURITIES	63,394,803.	18,109,105.
RENT RECEIVABLE	0.	0.
DUE FROM AFFILIATED ORGANIZATIONS	179,143.	273,706.
OTHER RECEIVABLES	2,347.	721.
PREPAID EXPENSES	587,834.	155,479.
OTHER RECEIVABLES	9,569.	10,697.
TOTAL TO SCHEDULE H, LINE 1B(3)	71,277,849.	25,048,651.

SCHEDULE H	OTHER GENERAL INVESTMENTS	STATEMENT 3
------------	---------------------------	-------------

DESCRIPTION	BEGINNING	ENDING
FOREIGN OBLIGATIONS	0.	0.
TOTAL TO SCHEDULE H, LINE 1C(15)	0.	0.

SCHEDULE H	OTHER PLAN LIABILITIES	STATEMENT 4
DESCRIPTION	BEGINNING	ENDING
SETTLEMENT OF SECURITIES PURCHASED	62,727,776.	65,595,985.
DEFERRED LEASE INCENTIVE	397,540.	296,345.
NOTES PAYABLE	0.	0.
OBLIGATIONS TO REFUND COLLATERAL	364,215,790.	443,122,945.
TOTAL TO SCHEDULE H, LINE 1J	427,341,106.	509,015,275.

SCHEDULE H	OTHER INCOME	STATEMENT 5
DESCRIPTION	AMOUNT	
SETTLEMENT INCOME	7,460,800.	
TOTAL TO SCHEDULE H, LINE 2C	7,460,800.	

SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT 6
DESCRIPTION	AMOUNT	
OTHER ADMINISTRATIVE FEES	12,769,399.	
TOTAL TO SCHEDULE H, LINE 2I(4)	12,769,399.	