

**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

**2016**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

For calendar plan year 2016 or fiscal plan year beginning \_\_\_\_\_ and ending \_\_\_\_\_

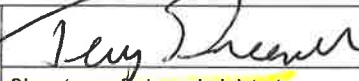

- A** This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- B** This return/report is:  a single-employer plan  a DFE (specify) \_\_\_\_\_
- the first return/report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

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

<b>1a</b> Name of plan SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN	<b>1b</b> Three-digit plan number (PN) ►	001
	<b>1c</b> Effective date of plan	01/01/1971
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BOARD OF TRUSTEES, SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN 9121 W RUSSELL RD STE 219 LAS VEGAS NV 89148	<b>2b</b> Employer Identification Number (EIN)	88-6016617
	<b>2c</b> Plan Sponsor's telephone number	702-369-0000
	<b>2d</b> Business code (see instructions)	721120

**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		10/10/17	Terry Greenwald
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10/10/17	Yvette Harris
	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
Preparer's name (including firm name, if applicable) and address (include room or suite number)			Preparer's telephone number

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

Form 5500 (2016)  
v. 160205

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN 88-6016617
	<b>3c</b> Administrator's telephone number 702-369-0000

<b>4</b> If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: <b>a</b> Sponsor's name	<b>4b</b> EIN  <b>4c</b> PN
---	-----------------------------------

<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	100430
<b>6</b> 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).		
<b>a(1)</b> Total number of active participants at the beginning of the plan year	<b>6a(1)</b>	54374
<b>a(2)</b> Total number of active participants at the end of the plan year	<b>6a(2)</b>	53599
<b>b</b> Retired or separated participants receiving benefits	<b>6b</b>	22147
<b>c</b> Other retired or separated participants entitled to future benefits	<b>6c</b>	24261
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c.	<b>6d</b>	100007
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<b>6e</b>	1007
<b>f</b> Total. Add lines 6d and 6e.	<b>6f</b>	101014
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>6g</b>	0.
<b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.	<b>6h</b>	0.
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<b>7</b>	113

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

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

<b>9a</b> Plan funding arrangement (check all that apply) (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	<b>9b</b> 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
---	---

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

<b>a Pension Schedules</b> (1) <input checked="" type="checkbox"/> <b>R</b> (Retirement Plan Information) (2) <input checked="" type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> (1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information - Small Plan) (3) <input type="checkbox"/> <b>A</b> (Insurance Information) (4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (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 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

---

<b>SCHEDULE C</b> <b>(Form 5500)</b> Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	<b>Service Provider Information</b> This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). <b>► File as an attachment to Form 5500.</b>	OMB No. 1210-0110 <hr/> <b>2016</b> <hr/> <b>This Form is Open to Public Inspection.</b>
---	--	--

For calendar plan year 2016 or fiscal plan year beginning		and ending	
<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN) ►		
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN		001	
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (EIN)		
BD. OF TRUSTEES, (OF THE ABOVE PLAN)	88-6016617		

**Part I Service Provider Information (see instructions)**

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

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

- a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions). . . . .  Yes  No
- b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

PIMCO	33-0629048
-------	------------

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

LANDMARK EQUITY ADVISORS, LLC	06-1519082
-------------------------------	------------

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

ENTRUST PARTNERS OFFSHORE, LP	90-0644478
-------------------------------	------------

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

MULTI-EMPLOYER PROPERTY TRUST	52-6218800
-------------------------------	------------

---

---

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

PNC BANK, NATIONAL ASSOCIATION 22-1146430

---

---

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

AFL-CIO HOUSING INVESTMENT TRUST 52-6220193

---

---

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

HAMILTON LANE ADVISORS, LLC 23-2962336

---

---

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

SCHRODER COMMODITY PORTFOLIO 13-4064414

---

---

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

ABS INVESTMENT MANAGEMENT LLC 13-4205457

---

---

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

PNC REALTY INVESTORS, INC. 22-1146430

---

---

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

LAZARD ASSET MANAGEMENT, LLC 05-0530199

---

---

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

MESIROW FINANCIAL PARTNERSHIP FD VI 27-3525125

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

GAM USA, INC.  
ONE ROCKEFELLER PLAZA 21ST FL  
NEW YORK NY 10020

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

NEW TOWER TRUST COMPANY 30-0872552

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

MCMORGAN & COMPANY LLC 52-2334338

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

ENTRUST SO NV CUL. & BART. PARTNERS 81-2026132

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

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

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

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

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)						
ZENITH AMERICAN SOLUTIONS 95-1702986						
(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	NONE	2684862	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
LOOMIS SAYLES & COMPANY 84-6391546						
(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	839360	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
INTECH INVESTMENT MANAGEMENT LLC 01-0614895						
(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	542397	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)						
J.P. MORGAN INVESTMENT MGMT, INC. 13-3200244						
(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 51 28	NONE	519551	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
TIMESSQUARE CAPITAL MANAGEMENT LLC 20-1665304						
(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 52 51	NONE	509402	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
JOHNSTON ASSET MANAGEMENT 13-3257590						
(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	505724	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)						
HORIZON ACTUARIAL SERVICES, LLC 26-1370698						
(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	NONE	486442	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
SEYFARTH & SHAW ATTORNEYS, LLP 36-2152202						
(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	NONE	386900	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
SYSTEMATIC FINANCIAL MGMT, L.P. 22-3367558						
(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 52 51 68	NONE	343685	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

**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	NONE	334318	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
WEDGE CAPITAL MANAGEMENT LLP 56-1557450						
(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 52 51 68	NONE	325445	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
COLUMBIA MGMT INVESTMENT ADVISORS 41-1533211						
(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 52 51 68	NONE	245716	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

**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)**

MARCO CONSULTING GROUP 36-3555078

(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?
16 27	NONE	225000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DIMENSIONAL FUND ADVISORS LP 30-0447847

(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	212392	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WESTERN ASSET MANAGEMENT COMPANY 95-2705767

(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	211246	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)						
LSV ASSET MANAGEMENT 23-2772200						
(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	208108	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
INTERCONTINENTAL REAL ESTATE CORP. 11-3786306						
(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	200599	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
WELLS FARGO BANK 30-0447847						
(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	NONE	130384	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)						
MILLER KAPLAN ARASE LLP 95-2036255						
(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	NONE	107000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
PARAMETRIC CLIFTON 20-0292745						
(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 52 51	NONE	73322	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)						
DAVIS, COWELL & BOWE, LLP 94-1709555						
(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	NONE	64851	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

UNITE HERE HEALTH 23-7385560

(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?
49	NONE	54711	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KEVIN CHRISTENSEN, ESQ 80-0024644

(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	NONE	31223	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BROWNSTEIN HYATT FARBER SCHRECK 26-1367865

(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	NONE	14796	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)**

PETERSON HOPE, PLLC 81-2901417

(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	NONE	10643	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	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.

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



**Part II Service Providers Who Fail or Refuse to Provide Information**

**4** Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

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

**SCHEDULE D  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

**DFE/Participating Plan Information**

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

► File as an attachment to Form 5500.

OMB No. 1210-0110

**2016**

This Form is Open to Public Inspection.

For calendar plan year 2016 or fiscal plan year beginning

and ending

**A** Name of plan

SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN

**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, (OF THE ABOVE PLAN)

**D** Employer Identification Number (EIN)

88-6016617

**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:

JP MORGAN STRATEGIC PROPERTY FUND

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

JP MORGAN ASSET MANAGEMENT

**c** EIN-PN 13-6038770 - 001

**d** Entity code C

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

53627206

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

LOOMIS SAYLES MULTISECTOR FULL DIS.

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

LOOMIS SAYLES & TRUST COMPANY, LLC

**c** EIN-PN 84-6391546 - 007

**d** Entity code C

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

88070476

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

MULTI-EMPLOYER PROPERTY TRUST

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

NEW TOWER TRUST COMPANY

**c** EIN-PN 52-6218800 - 001

**d** Entity code C

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

84068128

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

AFL-CIO BUILDING INVESTMENT TRUST

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

PNC BANK, NATIONAL ASSOCIATION

**c** EIN-PN 52-6328901 - 001

**d** Entity code C

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

107503049

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

DFA GROUP TRUST - SMALL CAP SUB TRU

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

DFA LP

**c** EIN-PN 23-6819730 - 005

**d** Entity code E

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

68748000

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

VOYA SENIOR LOAN TRUST

**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)

77606407

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

WESTERN ASSET US CORE PLUS, LLC

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

WESTERN ASSET MANAGEMENT CO.

**c** EIN-PN 20-1575788 - 001

**d** Entity code E

**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

60384000

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

Schedule D (Form 5500) 2016

6A6724 1.000

v. 160205

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

MCMORGAN INFRASTRUCTURE FUND

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

MCMORGAN INFRASTRUCTURE GP LLC

**c** EIN-PN 30-0808269-001**d** Entity code E**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

45820000

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



**SCHEDULE H  
(Form 5500)**

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

**2016**

**This Form is Open to Public Inspection**

For calendar plan year 2016 or fiscal plan year beginning		and ending	
<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN) ►	001	
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN			
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (EIN)		
BD. OF TRUSTEES, (OF THE ABOVE PLAN)		88-6016617	

**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
<b>a</b> Total noninterest-bearing cash . . . . .	<b>1a</b> 15200000	11911000
<b>b</b> Receivables (less allowance for doubtful accounts):		
(1) Employer contributions . . . . .	<b>1b(1)</b> 9193000	10049000
(2) Participant contributions. . . . .	<b>1b(2)</b>	
(3) Other . . . . .	<b>1b(3)</b> 10762000	7380000
<b>c</b> General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit) . . . . .	<b>1c(1)</b> 25322000	31005000
(2) U.S. Government securities. . . . .	<b>1c(2)</b>	
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred . . . . .	<b>1c(3)(A)</b>	
(B) All other. . . . .	<b>1c(3)(B)</b>	
(4) Corporate stocks (other than employer securities):		
(A) Preferred . . . . .	<b>1c(4)(A)</b>	
(B) Common . . . . .	<b>1c(4)(B)</b> 567700000	515880000
(5) Partnership/joint venture interests . . . . .	<b>1c(5)</b>	
(6) Real estate (other than employer real property) . . . . .	<b>1c(6)</b> 4484000	8423000
(7) Loans (other than to participants). . . . .	<b>1c(7)</b>	
(8) Participant loans . . . . .	<b>1c(8)</b>	
(9) Value of interest in common/collective trusts . . . . .	<b>1c(9)</b> 379244000	410875000
(10) Value of interest in pooled separate accounts . . . . .	<b>1c(10)</b>	
(11) Value of interest in master trust investment accounts . . . . .	<b>1c(11)</b>	
(12) Value of interest in 103-12 investment entities . . . . .	<b>1c(12)</b> 130853000	174952000
(13) Value of interest in registered investment companies (e.g., mutual funds) . . . . .	<b>1c(13)</b> 488350000	331268000
(14) Value of funds held in insurance company general account (unallocated contracts). . . . .	<b>1c(14)</b>	
(15) Other . . . . .	<b>1c(15)</b> 326757000	573547000

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

Schedule H (Form 5500) 2016  
v.160205

		(a) Beginning of Year	(b) End of Year
<b>1d</b>	Employer-related investments:		
(1)	Employer securities . . . . .	<b>1d(1)</b>	
(2)	Employer real property . . . . .	<b>1d(2)</b>	
<b>e</b>	Buildings and other property used in plan operation . . . . .	<b>1e</b>	
<b>f</b>	Total assets (add all amounts in lines 1a through 1e) . . . . .	<b>1f</b>	1957865000 2075290000
<b>Liabilities</b>			
<b>g</b>	Benefit claims payable . . . . .	<b>1g</b>	
<b>h</b>	Operating payables . . . . .	<b>1h</b>	1594000 1772000
<b>i</b>	Acquisition indebtedness . . . . .	<b>1i</b>	
<b>j</b>	Other liabilities . . . . .	<b>1j</b>	
<b>k</b>	Total liabilities (add all amounts in lines 1g through 1j) . . . . .	<b>1k</b>	1594000 1772000
<b>Net Assets</b>			
<b>l</b>	Net assets (subtract line 1k from line 1f) . . . . .	<b>1l</b>	1956271000 2073518000

**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
<b>Income</b>			
<b>a</b>	<b>Contributions:</b>		
(1)	Received or receivable in cash from: (A) Employers . . . . .	<b>2a(1)(A)</b>	106709000
	(B) Participants . . . . .	<b>2a(1)(B)</b>	
	(C) Others (including rollovers) . . . . .	<b>2a(1)(C)</b>	
(2)	Noncash contributions . . . . .	<b>2a(2)</b>	
(3)	Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2) . . . . .	<b>2a(3)</b>	106709000
<b>b</b>	<b>Earnings on investments:</b>		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit) . . . . .	<b>2b(1)(A)</b>	169000
	(B) U.S. Government securities . . . . .	<b>2b(1)(B)</b>	
	(C) Corporate debt instruments . . . . .	<b>2b(1)(C)</b>	
	(D) Loans (other than to participants) . . . . .	<b>2b(1)(D)</b>	
	(E) Participant loans . . . . .	<b>2b(1)(E)</b>	
	(F) Other . . . . .	<b>2b(1)(F)</b>	
	(G) Total interest. Add lines 2b(1)(A) through (F) . . . . .	<b>2b(1)(G)</b>	169000
(2)	Dividends: (A) Preferred stock . . . . .	<b>2b(2)(A)</b>	
	(B) Common stock . . . . .	<b>2b(2)(B)</b>	10395000
	(C) Registered investment company shares (e.g. mutual funds) . . . . .	<b>2b(2)(C)</b>	6103000
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C) . . . . .	<b>2b(2)(D)</b>	16498000
(3)	Rents . . . . .	<b>2b(3)</b>	
(4)	Net gain (loss) on sale of assets: (A) Aggregate proceeds . . . . .	<b>2b(4)(A)</b>	482860000
	(B) Aggregate carrying amount (see instructions) . . . . .	<b>2b(4)(B)</b>	469185000
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result . . . . .	<b>2b(4)(C)</b>	13675000
(5)	Unrealized appreciation (depreciation) of assets: (A) Real estate . . . . .	<b>2b(5)(A)</b>	
	(B) Other . . . . .	<b>2b(5)(B)</b>	132626000
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) . . . . .	<b>2b(5)(C)</b>	132626000

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts . . . . .	2b(6)	
(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)	-5747000
c Other income . . . . .	2c	88000
d Total income. Add all income amounts in column (b) and enter total . . . . .	2d	264018000

**Expenses**

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers . . . . .	2e(1)	134241000
(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)	134241000
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)	1296000
(2) Contract administrator fees . . . . .	2i(2)	2670000
(3) Investment advisory and management fees . . . . .	2i(3)	5332000
(4) Other . . . . .	2i(4)	3232000
(5) Total administrative expenses. Add lines 2i(1) through (4). . . . .	2i(5)	12530000
j Total expenses. Add all expense amounts in column (b) and enter total . . . . .	2j	146771000

**Net Income and Reconciliation**

k Net income (loss). Subtract line 2j from line 2d . . . . .	2k	117247000
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: MILLER KAPLAN ARASE LLP (2) EIN: 95-2036255

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
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) . . . . .	<b>4c</b>	X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.) . . . . .	<b>4d</b>	X	
<b>e</b> Was this plan covered by a fidelity bond? . . . . .	<b>4e</b>	X	500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? . . . . .	<b>4f</b>	X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? . . . . .	<b>4g</b>	X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? . . . . .	<b>4h</b>	X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) . . . . .	<b>4i</b>	X	
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.) . . . . .	<b>4j</b>	X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? . . . . .	<b>4k</b>	X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan? . . . . .	<b>4l</b>	X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) . . . . .	<b>4m</b>		
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3. . . . .	<b>4n</b>		
<b>o</b> Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service? . . . . .	<b>4o</b>		

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

**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 4007062. (See instructions.)

<b>Part V Trust Information</b>	
<b>6a</b> Name of trust	<b>6b</b> Trust's EIN
<b>6c</b> Name of trustee or custodian	<b>6d</b> Trustee's or custodian's telephone number



<p><b>SCHEDULE R</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Retirement Plan Information</b></p> <p>This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p>	<p>OMB No. 1210-0110</p> <p><b>2016</b></p> <hr/> <p>This Form is Open to Public Inspection.</p>
---	---	--

For calendar plan year 2016 or fiscal plan year beginning		and ending	
<b>A</b> Name of plan	<b>B</b> Three-digit plan number (PN)		
SOUTHERN NEVADA CULINARY AND BARTENDERS PENSION PLAN		001	
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500		<b>D</b> Employer Identification Number (EIN)	
BD. OF TRUSTEES, (OF THE ABOVE PLAN)		88-6016617	

**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): 88-6016617

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

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year. 3  0

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

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

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

6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	<b>6a</b>	<input style="width: 95%;" type="text"/>
b Enter the amount contributed by the employer to the plan for this plan year	<b>6b</b>	<input style="width: 95%;" type="text"/>
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)	<b>6c</b>	0

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 WYNN LAS VEGAS  
**b** EIN 88-0494875 **c** Dollar amount contributed by employer 9162819  
**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 07 Day 31 Year 2021  
**e** Contribution rate information (If more than one rate applies, check this box  and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)  
 (1) Contribution rate (in dollars and cents) 1.14  
 (2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer BELLAGIO  
**b** EIN 94-3373852 **c** Dollar amount contributed by employer 7783719  
**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 05 Day 31 Year 2018  
**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) 1.14  
 (2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer ARIA RESORT & CASINO  
**b** EIN 20-5396350 **c** Dollar amount contributed by employer 7198687  
**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 05 Day 31 Year 2018  
**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) 1.14  
 (2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer MANDALAY BAY  
**b** EIN 88-0384693 **c** Dollar amount contributed by employer 7021801  
**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 05 Day 31 Year 2018  
**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) 1.14  
 (2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer CAESAR'S PALACE  
**b** EIN 88-0097966 **c** Dollar amount contributed by employer 6603912  
**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 05 Day 31 Year 2018  
**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) 1.14  
 (2) Base unit measure:  Hourly  Weekly  Unit of production  Other (specify):

**a** Name of contributing employer MGM GRAND HOTEL, INC  
**b** EIN 94-3373856 **c** Dollar amount contributed by employer 6397960  
**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 11 Day 12 Year 2014  
**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) 1.14  
 (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 . . . . .	<b>14a</b>	
b The plan year immediately preceding the current plan year . . . . .	<b>14b</b>	
c The second preceding plan year . . . . .	<b>14c</b>	

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

a The corresponding number for the plan year immediately preceding the current plan year . . . . .	<b>15a</b>	1.04
b The corresponding number for the second preceding plan year . . . . .	<b>15b</b>	1.08

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

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

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

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

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

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

a Enter the percentage of plan assets held as:  
 Stock: 48.0 % Investment-Grade Debt: 12.3 % High-Yield Debt: 8.5 % Real Estate: 14.1 % Other: 17.1 %

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):

**Part VII IRS Compliance Questions**

**20a** Is the plan a 401(k) plan? If "No," skip b.  Yes  No

**20b** How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:  Design-based safe harbor  "Prior year" ADP test  "Current year" ADP test  N/A

**21a** What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:  Ratio percentage test  Average benefit test  N/A

**21b** Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?  Yes  No

**22a** If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS opinion letter or advisory letter, enter the date of the letter and the serial number

**22b** If the plan is an individually-designed plan that received a favorable determination letter from the IRS, enter the date of the most recent determination letter

**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

**2016**

**This Form is Open to Public  
Inspection**

For calendar plan year 2016 or fiscal plan year beginning \_\_\_\_\_ and ending \_\_\_\_\_

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

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

<b>A</b> Name of plan SOUTHERN NEVADA CULINARY AND BARTENDERS PLAN		<b>B</b> Three-digit plan number (PN) ► 001
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF BD. OF TRUSTEES, (OF THE ABOVE PLAN)		<b>D</b> Employer Identification Number (EIN) 88-6016617
<b>E</b> Type of plan: (1) <input checked="" type="checkbox"/> Multiemployer Defined Benefit (2) <input type="checkbox"/> Money Purchase (see instructions)		

**1a** Enter the valuation date: Month 01 Day 01 Year 2016

**b** Assets

(1) Current value of assets . . . . .	<b>1b(1)</b>	1956271000
(2) Actuarial value of assets for funding standard account . . . . .	<b>1b(2)</b>	2050789639

**c**

(1) Accrued liability for plan using immediate gain methods . . . . .	<b>1c(1)</b>	2220235710
(2) Information for plans using spread gain methods:		
(a) Unfunded liability for methods with bases . . . . .	<b>1c(2)(a)</b>	
(b) Accrued liability under entry age normal method. . . . .	<b>1c(2)(b)</b>	
(c) Normal cost under entry age normal method. . . . .	<b>1c(2)(c)</b>	
(3) Accrued liability under unit credit cost method. . . . .	<b>1c(3)</b>	2220235710

**d** Information on current liabilities of the plan:

(1) Amount excluded from current liability attributable to pre-participation service (see instructions)	<b>1d(1)</b>	
(2) "RPA '94" information:		
(a) Current liability. . . . .	<b>1d(2)(a)</b>	3785262798
(b) Expected increase in current liability due to benefits accruing during the plan year. . . . .	<b>1d(2)(b)</b>	126246758
(c) Expected release from "RPA '94" current liability for the plan year. . . . .	<b>1d(2)(c)</b>	148669197
(3) Expected plan disbursements for the plan year. . . . .	<b>1d(3)</b>	145885857

**Statement by Enrolled Actuary**

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

<b>SIGN HERE</b>	_____ Signature of actuary	09/27/2017 Date
	CARY FRANKLIN Type or print name of actuary	14-04013 Most recent enrollment number
	HORIZON ACTUARIAL SERVICES, LLC Firm name	818-691-2002 Telephone number (including area code)
	5200 LANKERSHIM BLVD STE 740 NORTH HOLLYWOOD CA 91601 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

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

Schedule MB (Form 5500) 2016  
v. 160205

**2** Operational information as of beginning of this plan year:

<b>a</b> Current value of assets (see instructions)	<b>2a</b>	1956271000
<b>b</b> "RPA '94" current liability/participant count breakdown:	<b>(1) Number of participants</b>	<b>(2) Current liability</b>
<b>(1)</b> For retired participants and beneficiaries receiving payment . . . . .	22997	1025181509
<b>(2)</b> For terminated vested participants . . . . .	22758	865452105
<b>(3)</b> For active participants:		
<b>(a)</b> Non-vested benefits . . . . .		39758176
<b>(b)</b> Vested benefits . . . . .		1854871008
<b>(c)</b> Total active . . . . .	51156	1894629184
<b>(4)</b> Total . . . . .	96911	3785262798
<b>c</b> If the percentage resulting from dividing line 2a by line 2b(4), column (2), is less than 70%, enter such percentage . . . . .	<b>2c</b>	51.68 %

**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
12/31/2016	106709000				
<b>Totals ▶</b>			<b>3(b)</b>	106709000	<b>3(c)</b>

**4** Information on plan status:

<b>a</b> Funded percentage for monitoring plan's status (line 1b(2) divided by line 1c(3)) . . . . .	<b>4a</b>	92.4 %
<b>b</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. . . . .	<b>4b</b>	N
<b>c</b> Is the plan making the scheduled progress under any applicable funding improvement or rehabilitation plan? . . . . .	Yes	No
<b>d</b> If the plan is in critical status or critical and declining status, were any benefits reduced (see instructions)? . . . . .	Yes	No
<b>e</b> If line d is "Yes," enter the reduction in liability resulting from the reduction in benefits (see instructions), measured as of the valuation date . . . . .	<b>4e</b>	
<b>f</b> If the rehabilitation plan projects emergence from critical status or critical and declining status, enter the plan year in which it is projected to emerge. If the rehabilitation plan is based on forestalling possible insolvency, enter the plan year in which insolvency is expected and check here <input type="checkbox"/> . . . . .	<b>4f</b>	

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

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

<b>j</b> If box h is checked, enter period of use of shortfall method . . . . .	<b>5j</b>	
<b>k</b> Has a change been made in funding method for this plan year? . . . . .	Yes	No
<b>l</b> If line k is "Yes," was the change made pursuant to Revenue Procedure 2000-40 or other automatic approval? . . . . .	Yes	No
<b>m</b> If line k is "Yes," and line m is "No," enter the date (MM-DD-YYYY) of the ruling letter (individual or class) approving the change in funding method. . . . .	<b>5m</b>	

**6 Checklist of certain actuarial assumptions:**

<b>a</b> Interest rate for "RPA '94" current liability. . . . .	<b>6a</b>	3.28%				
<b>b</b> Rates specified in insurance or annuity contracts. . . . .	Pre-retirement		Post-retirement			
	Yes	<input checked="" type="checkbox"/> No	N/A	Yes	<input checked="" type="checkbox"/> No	N/A
<b>c</b> Mortality table code for valuation purposes:						
<b>(1)</b> Males . . . . .	<b>6c(1)</b>	11			11	
<b>(2)</b> Females . . . . .	<b>6c(2)</b>	11F			11F	
<b>d</b> Valuation liability interest rate. . . . .	<b>6d</b>	7.00%			7.00%	
<b>e</b> Expense loading . . . . .	<b>6e</b>	10.2%	N/A	%	<input checked="" type="checkbox"/> N/A	
<b>f</b> Salary scale . . . . .	<b>6f</b>	%	<input checked="" type="checkbox"/> N/A			
<b>g</b> Estimated investment return on actuarial value of assets for year ending on the valuation date . . . . .	<b>6g</b>					5.0%
<b>h</b> Estimated investment return on current value of assets for year ending on the valuation date. . . . .	<b>6h</b>					1.1%

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

(1) Type of base	(2) Initial balance	(3) Amortization Charge/Credit
1	51559438	5290607

**8 Miscellaneous information:**

**a** If a waiver of a funding deficiency has been approved for this plan year, enter the date (MM-DD-YYYY) of the ruling letter granting the approval. . . . . **8a**  

**b(1)** Is the plan required to provide a projection of expected benefit payments? (See the instructions.) If "Yes," attach a schedule. . . . .  Yes  No

**b(2)** Is the plan required to provide a Schedule of Active Participant Data? (See the instructions.) If "Yes," attach a schedule. . . . .  Yes  No

**c** Are any of the plan's amortization bases operating under an extension of time under section 412(e) (as in effect prior to 2008) or section 431(d) of the Code? . . . . .  Yes  No

**d** If line c is "Yes," provide the following additional information:

**(1)** Was an extension granted automatic approval under section 431(d)(1) of the Code? . . . . .  Yes  No

**(2)** If line 8d(1) is "Yes," enter the number of years by which the amortization period was extended . . . . . **8d(2)**  

**(3)** Was an extension approved by the Internal Revenue Service under section 412(e) (as in effect prior to 2008) or 431(d)(2) of the Code? . . . . .  Yes  No

**(4)** If line 8d(3) is "Yes," enter number of years by which the amortization period was extended (not including the number of years in line (2)). . . . . **8d(4)**  

**(5)** If line 8d(3) is "Yes," enter the date of the ruling letter approving the extension . . . . . **8d(5)**  

**(6)** If line 8d(3) is "Yes," is the amortization base eligible for amortization using interest rates applicable under section 6621(b) of the Code for years beginning after 2007? . . . . .  Yes  No

**e** If box 5h is checked or line 8c is "Yes," enter the difference between the minimum required contribution for the year and the minimum that would have been required without using the shortfall method or extending the amortization base(s) . . . . . **8e**  

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

**Charges to funding standard account:**

<b>a</b> Prior year funding deficiency, if any . . . . .	<b>9a</b>	
<b>b</b> Employer's normal cost for plan year as of valuation date. . . . .	<b>9b</b>	67950917
<b>c</b> Amortization charges as of valuation date:	Outstanding balance	
<b>(1)</b> All bases except funding waivers and certain bases for which the amortization period has been extended . . . . .	<b>9c(1)</b>	1030178409
<b>(2)</b> Funding waivers . . . . .	<b>9c(2)</b>	
<b>(3)</b> Certain bases for which the amortization period has been extended. <b>9c(3)</b>		
<b>d</b> Interest as applicable on lines 9a, 9b, and 9c . . . . .	<b>9d</b>	14193773
<b>e</b> Total charges. Add lines 9a through 9d . . . . .	<b>9e</b>	216961960

**Credits to funding standard account:**

<b>f</b> Prior year credit balance, if any . . . . .	<b>9f</b>	375333135
<b>g</b> Employer contributions. Total from column (b) of line 3. . . . .	<b>9g</b>	106709000
	Outstanding balance	
<b>h</b> Amortization credits as of valuation date . . . . .	<b>9h</b>	485399204
<b>i</b> Interest as applicable to end of plan year on lines 9f, 9g, and 9h . . . . .	<b>9i</b>	88325790
		35568471

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

<b>(1)</b> ERISA FFL (accrued liability FFL) . . . . .	<b>9j(1)</b>	759206789
<b>(2)</b> "RPA '94" override (90% current liability FFL) . . . . .	<b>9j(2)</b>	1464932248
<b>(3)</b> FFL credit . . . . .	<b>9j(3)</b>	
<b>k (1)</b> Waived funding deficiency . . . . .	<b>9k(1)</b>	
<b>(2)</b> Other credits . . . . .	<b>9k(2)</b>	
<b>l</b> Total credits. Add lines 9f through 9i, 9j(3), 9k(1), and 9k(2) . . . . .	<b>9l</b>	605936396
<b>m</b> Credit balance: If line 9l is greater than line 9e, enter the difference . . . . .	<b>9m</b>	388974436
<b>n</b> Funding deficiency: If line 9e is greater than line 9l, enter the difference . . . . .	<b>9n</b>	

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

<b>(1)</b> Due to waived funding deficiency accumulated prior to the 2016 plan year . . . . .	<b>9o(1)</b>	
<b>(2)</b> Due to amortization bases extended and amortized using the interest rate under section 6621(b) of the Code:		
<b>(a)</b> Reconciliation outstanding balance as of valuation date . . . . .	<b>9o(2)(a)</b>	
<b>(b)</b> Reconciliation amount (line 9c(3) balance minus line 9o(2)(a)) . . . . .	<b>9o(2)(b)</b>	
<b>(3)</b> Total as of valuation date . . . . .	<b>9o(3)</b>	
<b>10</b> Contribution necessary to avoid an accumulated funding deficiency. (See instructions.) . . . . .	<b>10</b>	
<b>11</b> Has a change been made in the actuarial assumptions for the current plan year? If "Yes," see instructions . . . . .		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

**Authorized Multiemployer Plan e-Signature Affidavit**


**Southern Nevada Culinary and Bartenders Pension Plan; E.I.N. 88-6016617; Plan No. 001**


**Form 5500 for the year beginning January 1, 2016 and ending December 31, 2016**

By signing below, we represent that we are authorized to act on behalf of the Board of Trustees of the above referenced plan, which is the plan administrator, and we authorize Miller Kaplan Arase LLP ("MKA") to electronically submit Form 5500 on its behalf under the "additional e-signature option." MKA will maintain a copy of this authorization for its records.

We have manually signed the Form 5500 and understand that MKA will attach to the electronic filing, in addition to any other required schedules or attachments, a true and correct PDF copy of the first two pages of the completed Form 5500 bearing our manual signatures. We further understand that the PDF image of our manual signatures will be included with the Form 5500 posted by the U.S. Department of Labor (DOL) on the Internet for public disclosure.

We understand that MKA will communicate to us, and to the Board of Trustees of the plan, any inquiries and information received from EFAST2, DOL, IRS or PBGC regarding this Form 5500 annual return/report.

 - Terry Greenwald 10/10/17  
UNION TRUSTEE (Print Name - Signature - Date)

 - Yvette Harris - 10/10/17  
EMPLOYER TRUSTEE (Print Name - Signature - Date)