

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 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
 ▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Part I Annual Report Identification Information

For calendar plan year 2015 or fiscal plan year beginning 07/01/2015 and ending 06/30/2016

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); or
 a single-employer plan; a DFE (specify) _____

B This return/report is: the first return/report; the final return/report;
 an amended return/report; a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here.

D Check box if filing under: Form 5558; automatic extension; the DFVC program;
 special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan BUFFALO LABORERS WELFARE FUND	1b Three-digit plan number (PN) ▶ 501
	1c Effective date of plan 06/01/1956
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BUFFALO LABORERS WELFARE FUND THOMAS L PANEK 25 TYROL DR STE 200 CHEEKTOWAGA, NY 14227-2715	2b Employer Identification Number (EIN) 16-0806902
	2c Plan Sponsor's telephone number 716-894-8061
	2d Business code (see instructions) 561110

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	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
	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

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5 2458
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year..... a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits..... d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits..... f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 2458 6a(2) 2135 6b 6c 6d 2135 6e 6f 2135 6g 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7 155
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4C	

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> <u>5</u> A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
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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 2015 Form M-1 annual report. If the plan was not required to file the 2015 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 _____

<p align="center">SCHEDULE A (Form 5500)</p> <p align="center">Department of the Treasury Internal Revenue Service</p> <hr/> <p align="center">Department of Labor Employee Benefits Security Administration</p> <hr/> <p align="center">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2015</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2015 or fiscal plan year beginning 07/01/2015 and ending 06/30/2016

<p>A Name of plan <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>D Employer Identification Number (EIN) <u>16-0806902</u></p>	

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

1 Coverage Information:

(a) Name of insurance carrier
HEALTH NOW NEW YORK DBA BLUE CROSS OF WNY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>16-1105741</u>	<u>55204</u>	<u>00990214</u>	<u>14</u>	<u>07/01/2015</u>	<u>06/30/2016</u>

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

<p>(a) Total amount of commissions paid <u>1925</u></p>	<p>(b) Total amount of fees paid</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
LYTLE ASSOCIATES INC 101 LANG BLVD
GRAND ISLAND, NY 14072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>1925</u>			<u>3</u>

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

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

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

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

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	133690
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

<p align="center">SCHEDULE A (Form 5500)</p> <p align="center">Department of the Treasury Internal Revenue Service</p> <hr/> <p align="center">Department of Labor Employee Benefits Security Administration</p> <hr/> <p align="center">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2015</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2015 or fiscal plan year beginning 07/01/2015 and ending 06/30/2016

<p>A Name of plan <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>D Employer Identification Number (EIN) <u>16-0806902</u></p>	

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

1 Coverage Information:

(a) Name of insurance carrier
PRUDENTIAL RETIREMENT INSURANCE AND ANNUITY COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>06-1050034</u>	<u>93629</u>	<u>069020</u>		<u>07/01/2015</u>	<u>06/30/2016</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	0

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

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

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	5019934
c Additions: (1) Contributions deposited during the year	7c(1)	750000
	7c(2)	
	7c(3)	126962
	7c(4)	
	7c(5)	
	(6) Total additions	7c(6)
d Total of balance and additions (add lines 7b and 7c(6))	7d	5896896
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	5896896

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs ▶

Part IV Provision of Information

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

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

<p align="center">SCHEDULE A (Form 5500)</p> <p align="center">Department of the Treasury Internal Revenue Service</p> <hr/> <p align="center">Department of Labor Employee Benefits Security Administration</p> <hr/> <p align="center">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2015</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2015 or fiscal plan year beginning 07/01/2015 and ending 06/30/2016

<p>A Name of plan <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>D Employer Identification Number (EIN) <u>16-0806902</u></p>	

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

1 Coverage Information:

(a) Name of insurance carrier
HEALTH NOW NEW YORK INC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>16-1105741</u>	<u>55204</u>	<u>00413676</u>	<u>14</u>	<u>07/01/2015</u>	<u>06/30/2016</u>

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

<p>(a) Total amount of commissions paid <u>1575</u></p>	<p>(b) Total amount of fees paid</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
LYTLE ASSOCIATES INC 101 LANG BLVD
GRAND ISLAND, NY 14072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>1575</u>			<u>3</u>

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

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

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a			26637
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b			

Specify nature of costs ▶

Part IV Provision of Information

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

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

<p align="center">SCHEDULE A (Form 5500)</p> <p align="center">Department of the Treasury Internal Revenue Service</p> <hr/> <p align="center">Department of Labor Employee Benefits Security Administration</p> <hr/> <p align="center">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p align="center">▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p align="center">2015</p> <hr/> <p align="center">This Form is Open to Public Inspection</p>
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For calendar plan year 2015 or fiscal plan year beginning 07/01/2015 and ending 06/30/2016

<p>A Name of plan <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>D Employer Identification Number (EIN) <u>16-0806902</u></p>	

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

1 Coverage Information:

(a) Name of insurance carrier
INDEPENDENT HEALTH

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>16-1483784</u>	<u>47034</u>	<u>31709</u>	<u>752</u>	<u>07/01/2015</u>	<u>06/30/2016</u>

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

<p>(a) Total amount of commissions paid <u>76641</u></p>	<p>(b) Total amount of fees paid</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
LYTLE ASSOCIATES 101 LANG BLVD
GRAND ISLAND, NY 14072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>76641</u>			<u>3</u>

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

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

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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

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

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

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

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b		
c Additions: (1) Contributions deposited during the year	7c(1)		
	7c(2)		
	7c(3)		
	7c(4)		
	7c(5)		
	(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d		
e Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	(2) Administration charge made by carrier	7e(2)	
	(3) Transferred to separate account	7e(3)	
	(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)		
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f		

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	3903487
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2015</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
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For calendar plan year 2015 or fiscal plan year beginning 07/01/2015 and ending 06/30/2016

<p>A Name of plan <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BUFFALO LABORERS WELFARE FUND</u></p>	<p>D Employer Identification Number (EIN) <u>16-0806902</u></p>	

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

1 Coverage Information:

(a) Name of insurance carrier
THE HARTFORD

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>06-0838648</u>	<u>70815</u>	<u>872808-G</u>	<u>544</u>	<u>10/01/2014</u>	<u>09/30/2015</u>

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

<p>(a) Total amount of commissions paid <u>4859</u></p>	<p>(b) Total amount of fees paid</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
LYTLE ASSOCIATES INC.
101 LANG BLVD
PO BOX 470
GRAND ISLAND, NY 14072

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>4859</u>			<u>3</u>

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

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

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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

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

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

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

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	122036
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2015 This Form is Open to Public Inspection.
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For calendar plan year 2015 or fiscal plan year beginning 07/01/2015 and ending 06/30/2016

A Name of plan <u>BUFFALO LABORERS WELFARE FUND</u>	B Three-digit plan number (PN) ▶	<u>501</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>BUFFALO LABORERS WELFARE FUND</u>	D Employer Identification Number (EIN) <u>16-0806902</u>	

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

<u>BLACKROCK ADVISORS, LLC</u>	<u>40 EAST 52ND STREET NEW YORK, NY 10022</u>
<u>23-2784752</u>	

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

<u>PIMCO FUNDS</u>	<u>840 NEWPORT CENTER DRIVE NEWPORT BEACH, CA 92660</u>
<u>33-0629048</u>	

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

<u>PRUDENTIAL RETIREMENT INSURANCE CO</u>	<u>280 TRUMBULL STREET HARTFORD, CT 06102</u>
<u>06-1050034</u>	

(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

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(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)

(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)

THOMAS L PANEK

25 TYROL DRIVE
SUITE 200
CHEEKTOWAGA, NY 14227

16-0806902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	126245	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

TRACY BAUGHER

25 TYROL DRIVE
SUITE 200
CHEEKTOWAGA, NY 14227

16-0806902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	77779	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

GORLICK KRAVITZ AND LISTHAUS P C

17 STATE STREET
4TH FLOOR
NEW YORK, NY 10004

13-3790829

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	N/A	73699	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

PROSKAUER ROSE LLP

ELEVEN TIMES SQUARE
NEW YORK, NY 10036

13-1840454

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	N/A	56641	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

JOANNE CHIAVETTA

25 TYROL DRIVE
SUITE 200
CHEEKTOWAGA, NY 14227

16-0806902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	54035	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

JULIE MURDOLA

25 TYROL DRIVE
SUITE 200
CHEEKTOWAGA, NY 14227

16-0806902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	47927	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

NYS HEALTH AND SAFETY FUND

18 CORPORATE WOODS
3RD FLOOR
ALBANY, NY 12211

22-3110941

(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	N/A	45074	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

JBM COMPUTER CONSULTANTS

20 NORTH AMERICAN DRIVE
WEST SENECA, NY 14224

16-1173118

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	N/A	44316	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

LUMSDEN & MCCORMICK LLP

CYCLORAMA BUILDING
369 FRANKLIN STREET
BUFFALO, NY 14202

16-0765486

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	N/A	37645	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

SHERRI KOESTLER

25 TYROL DRIVE
SUITE 200
CHEEKTOWAGA, NY 14227

16-0806902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	32402	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

JOE MCCARTHY AND ASSOCIATES

7644 RT 31 WEST
BALDWINVILLE, NY 13027

16-1125088

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	N/A	23559	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

EMPLOYEE RESOURCE INC

77 BROADWAY
SUITE 110
BUFFALO, NY 14203

16-1410179

(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	N/A	22100	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

M&T BANK

ONE M AND T PLAZA
BUFFALO, NY 14203

16-6265706

(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	N/A	11419	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

SEGAL CO

333 WEST 34TH STREET
NEW YORK, NY 10001

13-1835864

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
17	N/A	8088	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

EMILY BAUGHER

25 TYROL DRIVE
SUITE 200
CHEEKTOWAGA, NY 14227

16-0806902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30	EMPLOYEE	6912	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input 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)

THE BOGDAHN GROUP

4901 VINELAND ROAD
SUITE 600
ORLANDO, FL 32811

59-3676225

(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	N/A	5000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2015 This Form is Open to Public Inspection
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For calendar plan year 2015 or fiscal plan year beginning **07/01/2015** and ending **06/30/2016**

A Name of plan BUFFALO LABORERS WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BUFFALO LABORERS WELFARE FUND	D Employer Identification Number (EIN) 16-0806902

Part I Asset and Liability Statement

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

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	75042	84115
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1786000	1896000
(2) Participant contributions		
(3) Other.....	533229	521726
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1034075	584826
(2) U.S. Government securities.....		
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred		
(B) All other.....		
(4) Corporate stocks (other than employer securities):		
(A) Preferred		
(B) Common		
(5) Partnership/joint venture interests	775	775
(6) Real estate (other than employer real property)		
(7) Loans (other than to participants)		
(8) Participant loans		
(9) Value of interest in common/collective trusts.....		
(10) Value of interest in pooled separate accounts.....		
(11) Value of interest in master trust investment accounts		
(12) Value of interest in 103-12 investment entities		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	9020958	9329952
(14) Value of funds held in insurance company general account (unallocated contracts).....	6048070	6943624
(15) Other		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation.....	1e	35688	28794
f Total assets (add all amounts in lines 1a through 1e)	1f	18533837	19389812

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h	308436	176183
i Acquisition indebtedness	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	308436	176183

Net Assets

l Net assets (subtract line 1k from line 1f).....	1l	18225401	19213629
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Part II Income and Expense Statement

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

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	10085918	
(B) Participants	2a(1)(B)	578511	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		10664429
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	808	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	165620	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		
(2) Dividends: (A) Preferred stock.....			
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	219726	
(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds			
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....			
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

	(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)	-214260
c Other income.....	2c	218571
d Total income. Add all income amounts in column (b) and enter total.....	2d	11054894

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	4993860
(2) To insurance carriers for the provision of benefits	2e(2)	4407826
(3) Other	2e(3)	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)	9401686
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)	201049
(2) Contract administrator fees.....	2i(2)	
(3) Investment advisory and management fees	2i(3)	5000
(4) Other	2i(4)	458931
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)	664980
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j	10066666

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	988228
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: LUMSDEN AND MCCORMICK LLP **(2)** EIN: 16-0765486

d The opinion of an independent qualified public accountant is **not attached** because:

(1) This form is filed for a CCT, PSA, or MTIA. **(2)** It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

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

During the plan year:

	Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X		
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....		X		

	Yes	No	N/A	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X		
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X		
e Was this plan covered by a fidelity bond?	X			2000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X		
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	X			775
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)		X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X		
l Has the plan failed to provide any benefit when due under the plan?		X		
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)				
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.				
o Did the plan trust incur unrelated business taxable income?		X		
p Were in-service distributions made during the plan year?		X		

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

Part V Trust Information

6a Name of trust	6b Trust's EIN
6c Name of trustee or custodian	6d Trustee's or custodian's telephone number

BUFFALO LABORERS' WELFARE FUND

E.I.N.: 16-0806902
 Plan Number: 501
 Additional Information
 Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

June 30, 2016

(a)	(b)	(c)	(d)	(e)
*	Identity of Issue	Description	Shares/ Par Value	Cost Current Value
Money Market Funds:				
	M&T Bank Savings Account		584,826	\$ 584,826 \$ 584,826
Mutual Funds:				
	PIMCO All Asset Institutional Fund		155,530	1,917,601 1,720,166
	PIMCO Low Duration Fund		572,728	5,911,106 5,658,552
	BlackRock Global Allocation Fund		108,522	2,112,931 1,951,234
				<u>9,941,638 9,329,952</u>
Annuities and GICS:				
	Allianz Life Insurance Co., 3.00%, 1/28/2018		704,328	704,328 704,328
	Fidelity & Guaranty Life Ins. Co., 3.75%, 1/29/2017		342,400	342,400 342,400
				<u>1,046,728 1,046,728</u>
Limited Partnerships:				
	Andover Associates, L.P.		750	750 775
Fully Benefit-Responsive Investment Contract:				
	Prudential Fixed Rate Fund, 2.45%			<u>5,896,896 5,896,896</u>
	Total investments			<u>\$ 17,470,838 \$ 16,859,177</u>

* No investments are with parties-in-interest.

BUFFALO LABORERS' WELFARE FUND

**FINANCIAL STATEMENTS
WITH ADDITIONAL INFORMATION**

June 30, 2016

INDEPENDENT AUDITORS' REPORT

The Trustees
Buffalo Laborers' Welfare Fund

We have audited the accompanying statements of net assets available for benefits and statements of benefit obligations of Buffalo Laborers' Welfare Fund (the Fund) as of June 30, 2016 and 2015, and the related statements of changes in net assets available for benefits and statements of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Fund's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Fund's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Fund as of June 30, 2016 and 2015, and the changes in its financial status for the years then ended in accordance with accounting principles generally accepted in the United States of America.



January 17, 2017

BUFFALO LABORERS' WELFARE FUND

Statements of Net Assets Available for Benefits

June 30,	2016	2015
Assets		
Investments:		
At fair value (Note 3):		
Money market funds	\$ 584,826	\$ 1,034,075
Mutual funds	9,329,952	9,020,958
Annuities and GICS	1,046,728	1,026,213
Limited partnerships	775	775
	<u>10,962,281</u>	11,082,021
At contract value:		
Fully benefit-responsive investment contract (Note 4)	5,896,896	5,021,857
	<u>16,859,177</u>	<u>16,103,878</u>
Receivables:		
Employer contributions, net of allowance for doubtful accounts of \$313,000 and \$280,000	1,896,000	1,786,000
Due from related funds (Note 5)	28,843	24,207
Investment income	158,811	140,666
	<u>2,083,654</u>	<u>1,950,873</u>
Cash	84,115	75,042
Prepaid expenses	334,072	368,356
Property and equipment, net (Note 6)	28,794	35,688
	<u>19,389,812</u>	<u>18,533,837</u>
Liabilities		
Accounts payable and accrued expenses	176,183	308,436
	<u>176,183</u>	<u>308,436</u>
Net assets available for benefits	<u>\$ 19,213,629</u>	<u>\$ 18,225,401</u>

See accompanying notes.

BUFFALO LABORERS' WELFARE FUND

Statements of Changes in Net Assets Available for Benefits

For the years ended June 30,	2016	2015
Additions		
Investment income:		
Net depreciation in fair value of mutual funds	\$ (214,260)	\$ (561,466)
Net depreciation in fair value of limited partnerships	-	(2,180)
Dividends	219,726	503,607
Interest	166,428	103,242
	<u>171,894</u>	<u>43,203</u>
Less investment expenses	5,000	5,408
	<u>166,894</u>	<u>37,795</u>
Employer contributions	10,085,918	10,560,441
Penalties and late fees - employer contributions	60,713	72,257
Member contributions	578,511	626,057
Securities litigation proceeds (Note 9)	140,705	60,812
Other	17,153	4,304
Total additions	<u>11,049,894</u>	<u>11,361,666</u>
Deductions		
Health and welfare expenses	9,284,292	8,976,399
Life insurance premiums	117,394	114,566
Administrative expenses - net	659,980	727,874
Total deductions	<u>10,061,666</u>	<u>9,818,839</u>
Net change	988,228	1,542,827
Net assets available for benefits - beginning	<u>18,225,401</u>	<u>16,682,574</u>
Net assets available for benefits - ending	<u>\$ 19,213,629</u>	<u>\$ 18,225,401</u>

See accompanying notes.

BUFFALO LABORERS' WELFARE FUND

Statements of Fund's Benefit Obligations

June 30,	2016	2015
Amounts currently payable	\$ 5,000	\$ 20,000
Postretirement death benefit obligations, net of amounts currently payable:		
Retired participants	2,215,000	2,055,000
Disabled participants	631,000	592,000
Active participants fully eligible and not yet fully eligible for benefits	1,032,000	822,000
Terminated participants fully eligible for benefits	381,000	337,000
Fund's total benefit obligations	\$ 4,264,000	\$ 3,826,000

See accompanying notes.

BUFFALO LABORERS' WELFARE FUND

Statements of Changes in Fund's Benefit Obligations

For the years ended June 30,	2016	2015
Amounts currently payable to or for participants, beneficiaries and dependents:		
Balance at beginning of year	\$ 20,000	\$ -
Net change during year:		
Claims reported and approved for payment	165,000	240,000
Claims paid	<u>(180,000)</u>	<u>(220,000)</u>
Balance at end of year	<u>5,000</u>	<u>20,000</u>
Other obligations for current benefit coverage, at present value of estimated amounts:		
Balance at beginning of year	3,806,000	3,882,000
Net change during year:		
Retired participants	160,000	(63,000)
Disabled participants	39,000	(12,000)
Active participants fully eligible and not yet fully eligible for benefits	210,000	18,000
Terminated participants fully eligible for benefits	<u>44,000</u>	<u>(19,000)</u>
Balance at end of year	<u>4,259,000</u>	<u>3,806,000</u>
Fund's total benefit obligation at end of year	\$ 4,264,000	\$ 3,826,000

Notes to Financial Statements

1. Description of the Fund:

The following description of Buffalo Laborers' Welfare Fund (the Fund) provides only general information. Participants should refer to the Fund agreement (the Plan) for a more complete description of the Fund's provisions.

General

The Fund provides health and other benefits to eligible participants who perform work within the jurisdiction of Laborers' International Union of North America, Local 210 (Laborers' Local 210). It was established pursuant to collective bargaining agreements between associations of local employers and Laborers' Local 210. Employers are primarily construction contractors located in the Western New York State area. The Fund is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

Participating contractors are required to make monthly contributions based on employee hours worked. Voluntary contributions from participants are allowed. At June 30, 2016 and 2015, the required contribution was \$10.92 per hour worked, credited as follows:

	<u>2016</u>	<u>2015</u>
Health and welfare	<u>\$ 10.58</u>	\$ 10.58
General benefit	<u>0.34</u>	0.34
	<u>\$ 10.92</u>	<u>\$ 10.92</u>

Amounts contributed by employers and employees are accumulated in each participant's health and welfare taxable and tax free accounts until payment is made for requested benefits. Contributions are allocated to the participant accounts based on a formula established by the Trustees and subject to the provisions of the Plan.

Benefits

The primary benefit of the Fund is to provide healthcare insurance for participants. Excess amounts accumulated in participants' accounts are eligible for other health and welfare benefits provided participants maintain required balances in their healthcare account. Benefits, subject to the provisions of the Plan, are provided for healthcare insurance, medical reimbursements, wage replacement assistance, and vacation.

Contributions are allocated to the participants' healthcare and taxable accounts based on a formula established by the Trustees. Participants are allowed to transfer funds from their wage replacement taxable account to their vacation account four times a year.

Amounts remaining in participants' accounts for healthcare are generally forfeited to the Plan at the death of the participant and spouse. Benefits for other purposes are generally forfeited to the Plan either at retirement or death of the participant.

Healthcare insurance is provided through one public health insurer, Independent Health. The benefits include hospital, surgical, prescription drug and major medical.

The Fund also reimburses participants for qualifying dependent care benefits, up to \$2,000 per year.

The Trustees may amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Any amendment may reduce or eliminate any benefit provided under the Plan and may result in the forfeiture of the balance of accounts. Under no circumstances will any Plan benefit become vested or non-forfeitable at any time with respect to any participant (active, inactive or retired) or beneficiary.

The Fund was established with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on collective bargaining agreements remaining in effect that provides for continued employer contributions to the Fund. Therefore, the Trustees reserve the right to terminate the Plan, in whole or in part, at any time and for any reason.

2. Summary of Significant Policies:

Basis of Accounting

The accompanying financial statements have been prepared using the accrual basis of accounting.

Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires the plan administrator to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Investments

All investments are held by trustee banks and investment managers who follow investment guidelines as documented within the Fund's Statement of Investment Policy. This statement governs the investment management of the Fund as well as its strategic asset allocation.

If available, quoted market prices are used to value investments. The amounts shown in Note 3 for limited partnerships have no quoted market price and represent estimated fair value. The estimated fair value is based on rates of return, collateral held, current year purchases of similar investments, appraised values and subsequent sales.

Certain investments are maintained in annuities and guaranteed interest accounts (GICS). The fair values approximate contract value. Contract value represents contributions made, plus interest, less withdrawals and administrative expenses.

The Fund maintains a fully benefit-responsive investment contract stated at contract value. Contract value, as reported to the Fund by the insurance company without further adjustment, represents contributions made, plus earnings, less withdrawals and administrative expenses. The Fund may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

Purchases and sales of investments are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Unrealized appreciation or depreciation on investments is charged or credited to the net assets of the Plan.

Contributions

Employer contributions are accrued based on hours worked during the year by covered employees. Contributions which apply to the current year that are received in the following year are reported as employer contributions receivable.

Cash:

Cash in financial institutions may exceed insured limits at various times during the year and subject the Fund to concentrations of credit risk.

Property and Equipment

Property and equipment is stated at cost net of accumulated depreciation. Depreciation is provided using the straight-line method over estimated useful asset lives. Maintenance and repairs are charged to operations as incurred; significant improvements are capitalized.

Postretirement Benefits

The Fund provides a \$5,000 postretirement death benefit to eligible participants. The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to participants' service rendered to the date of the financial statements. Postretirement benefits include future benefits expected to be paid for 1) currently retired or terminated participants and 2) active participants after retirement from service. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Fund's participating employers and from existing Fund assets.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical data to estimate future death benefits to be paid and to adjust such estimates for the time value of money.

The following are significant assumptions used in the valuations as of June 30, 2016 and 2015:

1. Life expectancy of participants - 1983 Group Annuity Mortality for males and females for healthy participants. Mortality rates were set forward for 10 years for disabled participants.
2. Interest rate – 3.25% (4.0% at June 30, 2015)
3. Retirement rates - Active participants who are eligible for unreduced retirement benefits from the Buffalo Laborers' Pension Fund (the Pension Fund) are assumed to retire at the rate of 15% per year prior to age 62, and at the rate of 100% (i.e., immediately) following the attainment of age 62. Active participants who are eligible for reduced benefits are assumed to retire at the rate of 3% per year prior to age 62, 5% per year from ages 62 to 64, and 100% (i.e., immediately) following the attainment of age 65. Inactive participants are assumed to retire at the earliest age they are eligible for unreduced retirement benefits from the Pension Fund, which is usually age 65.
4. Disability rates - 500% of the U.A.W. disability rates for males.
5. Termination rates - Active participants are assumed to terminate from active participation in the Plan at the rate of 30% at age 20, grading down to 0% at age 42.
6. Future hours - Hours worked in future years (for purposes of future eligibility) are assumed to be the maximum of hours worked in the past two plan years.

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

Income Taxes

The Fund is exempt from income taxes under the provisions of Section 501(c)(9) of the Internal Revenue Code. The Fund believes it is no longer subject to examination by Federal and State taxing authorities for years prior to 2013.

Subsequent Events:

The Fund has evaluated events and transactions for potential recognition or disclosure in the financial statements through January 17, 2017, the date the financial statements were available to be issued.

3. Investments and Fair Value Measurements:

Accounting guidance establishes a three-level fair value hierarchy that prioritizes the inputs used to measure assets at fair value. Inputs refer broadly to the assumptions that market participants would use in pricing the asset, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset and are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own perceptions about the assumptions market participants would use in pricing the asset and are based on the best information available.

The three levels of fair value hierarchy are as follows:

Level 1 - Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Fund has the ability to access on the reporting date.

Level 2 - Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs that are unobservable for the asset or liability.

The fair value hierarchy gives the highest priority to Level 1 inputs and the lowest priority to Level 3 inputs.

The fair values of investment assets valued at fair value are determined as follows as of June 30, 2016 and 2015:

	Based on		
	Level 1	Level 2	Level 3
2016			
Money market funds	\$ 584,826	\$ -	\$ -
Mutual funds	9,329,952	-	-
Annuities and GICS	-	-	1,046,728
Limited partnerships	-	-	775
	\$ 9,914,778	\$ -	\$ 1,047,503
2015			
Money market funds	\$ 1,034,075	\$ -	\$ -
Mutual funds	9,020,958	-	-
Annuities and GICS	-	-	1,026,213
Limited partnerships	-	-	775
	\$ 10,055,033	\$ -	\$ 1,026,988

Following is a reconciliation of activity for 2016 and 2015 for assets measured at fair value based on significant unobservable (non-market) information:

	2016	
	Limited Partnerships	Annuities and GICS
Balance, beginning of year	\$ 775	\$ 1,026,213
Purchases	-	20,515
Balance, end of year	\$ 775	\$ 1,046,728
	2015	
	Limited Partnerships	Annuities and GICS
Balance, beginning of year	\$ 2,955	\$ 1,801,422
Purchases	-	24,791
Sales	-	(800,000)
Unrealized loss	(2,180)	-
Balance, end of year	\$ 775	\$ 1,026,213

4. Fully Benefit-Responsive Investment Contract:

The Fund maintains a fully benefit-responsive investment contract with an insurance company. The insurance company maintains the contributions in its general account. The account is credited with earnings on the underlying investments and charged for withdrawals and administrative expenses. The contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Fund.

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon with the issuer, but it may not be less than one and one-half percent. Such interest rates are reviewed every six months for resetting.

Certain events limit the ability of the Fund to transact at contract value with the issuer. Such events include the following: (1) amendments to the fund agreements (including complete or partial fund termination or merger with another fund) or (2) the failure of the Fund to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. Additionally, participant benefit withdrawals from the contract at contract value are limited to the pro rata share of the contract in relation to total investments. The fund administrator does not believe that any events which would limit the Fund's ability to transact at contract value are probable of occurring.

The fully benefit-responsive investment contract does not permit the insurance company to terminate the agreement prior to the scheduled maturity date.

5. Related Party Transactions:

The Fund is related through common trustees to the Pension Fund, Buffalo Laborers' Training Fund (the Training Fund), and Buffalo Laborers' Security Fund (the Security Fund), and is reimbursed, based on periodic time studies, for office and administrative expenses incurred on behalf of these funds.

The following is a summary of balances and transactions with related parties at June 30, 2016 and 2015 and for the years then ended:

	2016	2015
Reimbursement of office and administrative expenses	\$ 313,435	\$ 299,899
Due from related funds at June 30	\$ 28,843	\$ 24,207

The Fund also shares office space with the Pension Fund and provides for monthly payments based on its pro-rata share of office space used as a percentage of the occupancy and other operating expenses paid by the Pension Fund. Rental expense paid for the years ended June 30, 2016 and 2015 was \$35,507 and 36,438. Amounts due to the Pension Fund and included in accounts payable at June 30, 2016 and 2015 were \$2,293 and \$2,297.

6. Property and Equipment:

	2016	2015
Furniture and fixtures	\$ 202,895	\$ 201,789
Less accumulated depreciation	174,101	166,101
	<u>\$ 28,794</u>	<u>\$ 35,688</u>

Depreciation expense for the years ended June 30, 2016 and 2015 was \$8,000 and \$8,316.

7. Life Insurance Premiums:

Life insurance premiums are a direct expense of the Fund. Life insurance coverage is provided to all pensioners and to active participants that are eligible pursuant to the Plan. Active participants that do not have the required hours for eligibility may pay directly to the Fund for coverage not to exceed one year.

8. Pension and Profit Sharing Plans:

Substantially all of the Fund's employees are covered by a contributory 401(k) profit sharing plan. Contributions to the plan are at the discretion of the Fund's Trustees for management employees, and the agreed upon hourly contribution rate for collectively bargained employees. The Trustees approved a 10% contribution for management participants employed by the Fund at December 31, 2015 and 2014. Total pension expense for 2016 and 2015 was \$36,909 and \$33,349.

In addition, the Fund contributed \$2.50 per hour worked in 2016 and 2015 by management employees to the Security Fund, a noncontributory defined contribution profit sharing plan. Contributions totaled \$10,320 and \$9,360 in 2016 and 2015.

9. Contingencies:

Loss Resulting from Madoff Securities Fraud:

In 2009, the Fund recognized a loss of approximately \$7,000,000 in connection with a securities fraud perpetrated by Bernard L. Madoff (Madoff). In 2010, the Fund received insurance proceeds of \$500,000 from the Securities Investor Protection Corporation. Additionally, the Fund received \$69,030, \$574,155, \$47,700, \$41,145, and \$123,930 from the Madoff bankruptcy trustee in 2012, 2013, 2014, 2015, and 2016, respectively.

During 2016 and 2015, the Fund received \$16,775 and \$1,010 from a limited partnership with Madoff exposure. These amounts are recorded as securities litigation proceeds on the statements of changes in net assets available for benefits for the years ended June 30, 2016 and 2015.

Additionally during 2015, the Fund received \$18,657 from a financial institution with Madoff exposure. This amount is recorded as securities litigation proceeds on the statement of changes in net assets available for benefits for the year ended June 30, 2015.

Other:

The Fund is involved in various legal proceedings which, in the opinion of management, will not have a material effect on the financial status of the Fund.

**INDEPENDENT AUDITORS' REPORT
ON ADDITIONAL INFORMATION**

The Trustees
Buffalo Laborers' Welfare Fund

We have audited the financial statements of Buffalo Laborers' Welfare Fund as of and for the years ended June 30, 2016 and 2015, and our report thereon dated January 17, 2017, which expressed an unmodified opinion on those financial statements, appears on page 1. Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedules of health and welfare expenses and administrative expenses are presented for purposes of additional analysis and are not a required part of the financial statements. The schedules of assets held at end of year as of June 30, 2016, and reportable transactions for the year then ended are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Fund's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.



January 17, 2017

BUFFALO LABORERS' WELFARE FUND

Additional Information
Schedules of Health and Welfare Expenses

For the years ended June 30,	2016	2015
Member-directed benefits:		
Health insurance premiums paid	\$ 4,223,258	\$ 4,061,123
Supplemental unemployment benefits	2,084,435	2,240,289
Vacation payments	1,714,835	1,413,082
Medical payment reimbursements	993,130	960,381
Death benefits	180,000	220,000
Withdrawals	11,671	-
Day care reimbursements	7,309	6,399
Life insurance	1,404	1,670
Payroll taxes - disability payments	1,076	10,530
	<hr/>	<hr/>
	9,217,118	8,913,474
Other health and welfare programs:		
National Health and Safety Fund	45,074	40,825
Membership Assistance Program	22,100	22,100
	<hr/>	<hr/>
	67,174	62,925
	<hr/>	<hr/>
	\$ 9,284,292	\$ 8,976,399

BUFFALO LABORERS' WELFARE FUND

Additional Information
Schedules of Administrative Expenses

For the years ended June 30,	2016	2015
Salaries and temporary services	\$ 345,300	\$ 331,601
Professional fees	201,049	263,480
Staff benefits	145,181	136,672
Computer programming and expense	44,316	28,546
Office rental	35,507	36,438
Bad debt - employer contributions	33,000	54,000
Payroll taxes	27,975	26,483
Office supplies and expense	27,486	30,376
Conventions and meetings	26,296	35,294
Insurance	23,969	27,703
Postage	22,640	11,330
Bank charges	11,419	12,721
Dues and subscriptions	8,554	8,103
Depreciation	8,000	8,316
Repairs and maintenance	7,448	12,213
Telephone	4,251	4,232
Printing and publications	729	-
Allowances and expenses, net of reimbursements	295	265
	973,415	1,027,773
Reimbursements from related funds	(313,435)	(299,899)
	\$ 659,980	\$ 727,874

See accompanying notes.

BUFFALO LABORERS' WELFARE FUND

E.I.N.: 16-0806902
Plan Number: 501
Additional Information
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

June 30, 2016

(a)	(b)	(c)	(c)	(d)	(e)
*	Identity of Issue	Description	Shares/ Par Value	Cost	Current Value
Money Market Funds:					
	M&T Bank Savings Account		584,826	\$ 584,826	\$ 584,826
Mutual Funds:					
	PIMCO All Asset Institutional Fund		155,530	1,917,601	1,720,166
	PIMCO Low Duration Fund		572,728	5,911,106	5,658,552
	BlackRock Global Allocation Fund		108,522	2,112,931	1,951,234
				<u>9,941,638</u>	<u>9,329,952</u>
Annuities and GICS:					
	Allianz Life Insurance Co., 3.00%, 1/28/2018		704,328	704,328	704,328
	Fidelity & Guaranty Life Ins. Co., 3.75%, 1/29/2017		342,400	342,400	342,400
				<u>1,046,728</u>	<u>1,046,728</u>
Limited Partnerships:					
	Andover Associates, L.P.		750	750	775
Fully Benefit-Responsive Investment Contract:					
	Prudential Fixed Rate Fund, 2.45%			5,896,896	5,896,896
	Total investments			<u>\$ 17,470,838</u>	<u>\$ 16,859,177</u>

* No investments are with parties-in-interest.

BUFFALO LABORERS' WELFARE FUND

E.I.N.: 16-0806902
 Plan Number: 501
 Additional Information
 Schedule H, Line 4j - Schedule of Reportable Transactions

For the year ended June 30, 2016

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of Issue	Description	Purchase Price	Selling Price	Cost of Asset	Current Value at Transaction Date	Net Gain (Loss)
M&T Bank Savings Account	Savings	\$ 3,210,808	\$ -	\$ -	\$ 3,210,808	\$ -
M&T Bank Savings Account	Savings	-	3,660,057	3,660,057	3,660,057	-

BUFFALO LABORERS' WELFARE FUND

E.I.N.: 16-0806902
 Plan Number: 501
 Additional Information
 Schedule H, Line 4j - Schedule of Reportable Transactions

For the year ended June 30, 2016

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of Issue	Description	Purchase Price	Selling Price	Cost of Asset	Current Value at Transaction Date	Net Gain (Loss)
M&T Bank Savings Account	Savings	\$ 3,210,808	\$ -	\$ -	\$ 3,210,808	\$ -
M&T Bank Savings Account	Savings		- 3,660,057	3,660,057	3,660,057	-