Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

Part I	Annual Report Id	entification Information						
For cale	ndar plan year 2014 or fisc	cal plan year beginning 05/01/2014		and ending 04/30/201	15			
A This	return/report is for:	a multiemployer plan;			g this box must attach a list of cordance with the form instructions); or			
		x a single-employer plan;	a DFE (spec	ify)				
R This	return/report is:	the first return/report;	the final retu	rn/report;				
D IIIIS	eturi/report is.	an amended return/report;	븜	year return/report (less than 1	2 months	s).		
C 16 (b)	alan Salaha Mangarak kansa		_					
		ained plan, check here	_		_	—		
D Chec	k box if filing under:	Form 5558;	automatic ex	tension;	_ the DF	FVC program;		
		special extension (enter description	on)					
Part	II Basic Plan Info	prmation—enter all requested inform	ation					
	ne of plan D AMBULANCE, LLC WEL	FARE BENEFITS PLAN			1b	Three-digit plan number (PN) ▶	501	
					1c	Effective date of plants of the original of th	an	
	•	ress; include room or suite number (em	ployer, if for a single	-employer plan)	2b	Employer Identifica	ition	
TRI-MEI	D AMBULANCE, LLC					Number (EIN) 91-1993087		
					2c	Plan Sponsor's tele	enhone	
						number		
	AST VALLEY HWY VA 98032	PO BOX SEATTLE	58250 E, WA 98138			888-448-1232 Business code (see		
, .		<u> </u>	-,				Э	
						621900		
Caution	: A penalty for the late or	r incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is	establis	shed.		
		er penalties set forth in the instructions, ell as the electronic version of this retur						
SIGN HERE	Filed with authorized/valid	electronic signature.	10/21/2015	KARI MAGGARD				
IILKL	Signature of plan admir	nistrator	Date	Enter name of individual signing as plan administrator				
SIGN HERE								
	Signature of employer/	plan sponsor	Date	Enter name of individual sign	gning as	employer or plan sp	onsor	
SIGN HERE								
HEKE	Signature of DFE		Date	Enter name of individual sign	gning as	DFE		
Preparei	's name (including firm na	me, if applicable) and address (include	room or suite number			telephone number		
				(op	otional)			

Form 5500 (2014) Page **2**

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 4c PN 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year 6a(1) a(2) Total number of active participants at the end of the plan year 6b c Other retired or separated participants entitled to future benefits 6c d Subtotal. Add lines 6a(2), 6b, and 6c.	3b Administrator's EIN		
EIN and the plan number from the last return/report: a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year 6a(1) a(2) Total number of active participants at the end of the plan year 6a(2) b Retired or separated participants receiving benefits 6b C Other retired or separated participants entitled to future benefits 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d	3c Administrator's telephone number		
EIN and the plan number from the last return/report: a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year 6a(1) a(2) Total number of active participants at the end of the plan year 6a(2) b Retired or separated participants receiving benefits 6b C Other retired or separated participants entitled to future benefits 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d			
5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year. 6a(1) a(2) Total number of active participants at the end of the plan year. 6a(2) b Retired or separated participants receiving benefits. 6b c Other retired or separated participants entitled to future benefits. 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d			
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year			
6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year 6a(1) a(2) Total number of active participants at the end of the plan year 6a(2) b Retired or separated participants receiving benefits 6b c Other retired or separated participants entitled to future benefits 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d	182		
a(2) Total number of active participants at the end of the plan year 6a(2) b Retired or separated participants receiving benefits 6b c Other retired or separated participants entitled to future benefits 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d			
b Retired or separated participants receiving benefits 6b c Other retired or separated participants entitled to future benefits 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 6d	180		
C Other retired or separated participants entitled to future benefits	142		
d Subtotal. Add lines 6a(2), 6b, and 6c.	1		
	0		
O Decembed participants whose hopeficiaries are receiving as are entitled to receive here-fits	143		
Deceased participants whose beneficiaries are receiving or are entitled to receive benefits			
f Total. Add lines 6d and 6e. 6f			
 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			
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)			
 If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instruction. If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instruction. 4A 4B 4D 4E 4L 			
9a Plan funding arrangement (check all that apply) (1)			
(1) A insurance (1) A insurance (2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts	acts		
(3) Trust (3) Trust			
(4) General assets of the sponsor (4) General assets of the sponsor			
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (S	ee instructions)		
a Pension Schedules b General Schedules			
(1) R (Retirement Plan Information) (1) H (Financial Information)			
(2) MB (Multiemployer Defined Benefit Plan and Certain Money (2) I (Financial Information – Small Pl	an)		
Purchase Plan Actuarial Information) - signed by the plan (3) A (Insurance Information)	,		
actuary (4) C (Service Provider Information)			
(3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information			
Information) - signed by the plan actuary (6) G (Financial Transaction Schedule	es)		

Form 5500 (2014) Page **3**

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)					
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.)					
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 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					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

Pension Benefit Guaranty Co	orporation		are required to provide the information ERISA section 103(a)(2). Inspection					
For calendar plan year 20	14 or fiscal pla	an year beginning 05/01/201	4	and en	ding 04	/30/2015		
A Name of plan TRI-MED AMBULANCE, I	LC WELFARI	E BENEFITS PLAN		B Three plan	e-digit number (PI	N) •	501	
	C Plan sponsor's name as shown on line 2a of Form 5500 TRI-MED AMBULANCE, LLC			D Employer Identification Number (EIN) 91-1993087				
on a separat	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 ca								
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or c	ontract year	
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To	
91-1467158	47055	6413700	12	26	05/01/20)14	04/30/2015	
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
		nmissions paid		(b) To	tal amount	of fees paid		
•		26626		0				
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	nersons)				
C 1 clocks receiving com					ons or fees	were paid		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid GALLAGHER BENEFIT SERVICES, INC. 777 108TH AVENUE NE, SUITE 200 BELLEVUE, WA 98004								
(b) Amount of sales ar	nd hoop	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	26626						3	
	(a) Name	and address of the agent, broke	er or other person to who	m commissi	ons or fees	were paid		
	(a) Name	and address of the agent, broke	or, or other person to who	111 001111111001	0110 01 1000	were paid		
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose)		(e) Organization code	

Schedule A (Form 5500) 2014 Page 2 - 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b 6c	
	Premiums due but unpaid at the end of the year					
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with th	ne acquisition or	6d	
	Specify nature of costs					
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			7 f	

Page 4
ployer(s) or members of the same emplicience-rated as a unit. Where contracts

Part III	Welfare	Benefit	Contract	Infor
	Schedule A	(Form 550	00) 2014	

Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same empiriformation may be combined for reporting purposes if such contracts are experi loyee organizations(s), the s cover individual employees,

	the entire group of such individual contracts w	rith each carrier may be treate	d as a ur	nit for purposes of this	report.		
8	Benefit and contract type (check all applicable boxes)						
	a X Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	e Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	oloyment	h X Prescription drug	
	i Stop loss (large deductible)	j HMO contract	kΧ	PPO contract		I Indemnity contract	
	m ☐ Other (specify) ▶	_	<u>—</u>			_	
9	Experience-rated contracts:						
	a Premiums: (1) Amount received	9	a(1)				
	(2) Increase (decrease) in amount due but unpaid	9	a(2)				
	(3) Increase (decrease) in unearned premium res	erve 9	a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		
	b Benefit charges (1) Claims paid	9	b(1)				
	(2) Increase (decrease) in claim reserves	9	b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		
	(4) Claims charged				9b(4)		
	c Remainder of premium: (1) Retention charges (or	n an accrual basis)					
	(A) Commissions	<u>9c</u> (1)(A)				
	(B) Administrative service or other fees	<u>9c</u> (1)(B)				
	(C) Other specific acquisition costs		1)(C)				
	(D) Other expenses		1)(D)				
	(E) Taxes		1)(E)				
	(F) Charges for risks or other contingencies		1)(F)				
	(G) Other retention charges	9c(1)(G)		1		
	(H) Total retention				9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in cash	n, or 🗌 c	redited.)	9c(2)		
	d Status of policyholder reserves at end of year: (1)	Amount held to provide bene	fits after	retirement	9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
	e Dividends or retroactive rate refunds due. (Do no	ot include amount entered in lin	ne 9c(2) .)	9e		
10	Nonexperience-rated contracts:	<u> </u>					
	a Total premiums or subscription charges paid to ca	arrier			10a	49	94713
	b If the carrier, service, or other organization incurre						
	retention of the contract or policy, other than repo	orted in Part I, line 2 above, rep	ort amo	unt	10b		
	Specify nature of costs						

Par	t IV	Provision of Information				
11	Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No	

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

			ERISA section 103(a)(2).	auon	Inspection
For calendar plan year 20	14 or fiscal pla	an year beginning 05/01/2014	and e	nding 04/30/2015	
A Name of plan TRI-MED AMBULANCE, LLC WELFARE BENEFITS PLAN			ee-digit n number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 TRI-MED AMBULANCE, LLC D Employer Identification Number (EIN) 91-1993087					er (EIN)
			Coverage, Fees, and Com s a unit in Parts II and III can be rep		
1 Coverage Information:					
(a) Name of insurance ca	rrier				
THE GUARDIAN LIFE IN	ISURANCE CO	OMPANY OF AMERICA			
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
13-5123390	64246	476879	105	05/01/2014	04/30/2015
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. List in line 3	the agents, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid					
5603					
3 Persons receiving com			s as needed to report all persons).		
GALLAGHER BENEFIT S		<u> </u>	r, or other person to whom commiss 108TH AVENUE NE, SUITE 200	sions or fees were paid	
ONLE NOTIEN BENEFIT	SERVICES, III	BEL	LEVUE, WA 98004		
(b) Amount of sales ar	nd hase	Fe	es and other commissions paid		
commissions pa		(c) Amount	(d) Purpos	(e) Organization code	
	5603				3
	(a) Name				
	(a) Name	and address of the agent, broker	r, or other person to whom commiss	sions or rees were paid	
(b) Amount of sales ar	nd base		es and other commissions paid		_
commissions pa	id	(c) Amount	(d) Purpos	se	(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
	а	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 corretention of the contract or policy, enter amount.	nnection with th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			7 f	

				_		
	Schedule A (Form 5500) 2014		Pa	ge 4		
Part II	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa purposes if such contracts ar	re experienc	e-rated as a unit. Whe	re contrac	
Bene	efit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	b X Dental	С	Vision		d X Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	oyment	h Prescription drug
i [Stop loss (large deductible)	i HMO contract	k	PPO contract		I Indemnity contract
m þ	J (1 2)	DISWEWBERWENT				
	erience-rated contracts:	Г	1			_
	Premiums: (1) Amount received		9a(1)			_
	(2) Increase (decrease) in amount due but unpai		9a(2)			_
	(3) Increase (decrease) in unearned premium re	<u></u>	9a(3)		00(4)	
	(4) Earned ((1) + (2) - (3))		9b(1)		9a(4)	
	Benefit charges (1) Claims paid(2) Increase (decrease) in claim reserves					_
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged			F	9b(4)	
	Remainder of premium: (1) Retention charges ((-)	
	(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)			

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

56034

Part IV **Provision of Information** 11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

9c(1)(F)

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

(F) Charges for risks or other contingencies.....

(H) Total retention.....

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier

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.....

10 Nonexperience-rated contracts:

Specify nature of costs

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

			ERISA section 103(a)(2).	lation	Inspection
For calendar plan year 20	14 or fiscal pla	an year beginning 05/01/2014	and o	ending 04/30/2015	
A Name of plan TRI-MED AMBULANCE, LLC WELFARE BENEFITS PLAN			ree-digit an number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 TRI-MED AMBULANCE, LLC D Employer Identification Number (EIN) 91-1993087					er (EIN)
			Coverage, Fees, and Cors a unit in Parts II and III can be re		
1 Coverage Information:					
(a) Name of insurance ca	rrier				
VISION SERVICE PLAN					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		r contract year
(5) EIIV	code	identification number	policy or contract year	(f) From	(g) To
23-7089668	53031	30019566	113	05/01/2014	04/30/2015
2 Insurance fee and come descending order of the		nation. Enter the total fees and to	otal commissions paid. List in line	3 the agents, brokers, an	d other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid					
581					
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all persons)	•	
OALLAGUED DENEET			r, or other person to whom commi	ssions or fees were paid	
GALLAGHER BENEFIT	SERVICES, IN	BEL	108TH AVENUE NE, SUITE 200 LEVUE, WA 98004		
(In) Amount of pales or		Fe	ees and other commissions paid		
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code
	581				3
	(a) Name	and address of the agent, broke	r, or other person to whom commi	ssions or fees were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid		
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
	а	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 corretention of the contract or policy, enter amount.	nnection with th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		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)			7 f	

Page 4		
		•

	Schedule A (Form 5500) 2014		Pa	ige 4			
Part II	If more than one contract covers the same guinformation may be combined for reporting puthe entire group of such individual contracts.	roup of employees of the s urposes if such contracts a with each carrier may be tr	are experienc	ce-rated as a unit. Wh	nere contracts		;,
8 Bene	efit and contract type (check all applicable boxes)	_		_		_	
а	Health (other than dental or vision)	b Dental	C	Vision	(d Life insurance	
е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unem	ployment h	h Prescription drug	
i Ē	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
m	Other (specify)	- Ц	_	_		_ .	
L	Cariot (opesaly)						
9 Expe	rience-rated contracts:						
a F	Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid	db	9a(2)				
	(3) Increase (decrease) in unearned premium res	serve	9a(3)		1		
	(4) Earned ((1) + (2) - (3))				. 9a(4)		
b	Benefit charges (1) Claims paid		9b(1)			_	
	(2) Increase (decrease) in claim reserves	_			T		
	(3) Incurred claims (add (1) and (2))				. 9b(3)		
	(4) Claims charged				. 9b(4)		
С	Remainder of premium: (1) Retention charges (c	´ F	0 (4)(4)			4	
	(A) Commissions		9c(1)(A)			4	
	(B) Administrative service or other fees	F	9c(1)(B) 9c(1)(C)			1	
	(C) Other specific acquisition costs	F	9c(1)(D)			4	
	(D) Other expenses	-	9c(1)(E)			}	
	(E) Taxes(F) Charges for risks or other contingencies.	-	9c(1)(F)			1	
	(G) Other retention charges					1	
	(H) Total retention				9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These						_
	Status of policyholder reserves at end of year: (1	_	_				
•	(2) Claim reserves	•			9d(2)		_
	(3) Other reserves				9d(3)		_
е	Dividends or retroactive rate refunds due. (Do n						
	nexperience-rated contracts:		. , ,	,	- N		
	Total premiums or subscription charges paid to o	carrier			. 10a	66	13
b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	, ,		•	. 10b		
Sp	ecify nature of costs				_		

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

,			ERISA section 103(a)(2).	liorriation		Inspection
For calendar plan year 20	14 or fiscal pla	in year beginning 05/01/2014		and ending	04/30/2015	
A Name of plan TRI-MED AMBULANCE, I	LC WELFARE	E BENEFITS PLAN	В	Three-digit plan number	(PN) •	501
C Plan sponsor's name a TRI-MED AMBULANCE, I		ne 2a of Form 5500	D	Employer Iden 91-1993087	tification Number	(EIN)
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca						
LIFE INSURANCE COM	PANY OF NOF	RTH AMERICA				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end		•	ontract year
(=, =	code	identification number	policy or contract year		(f) From	(g) To
23-1503749	65498	SGM605066	142	05/01	/2014	04/30/2015
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	tal commissions paid. List in	line 3 the ager	nts, brokers, and o	ther persons in
(a) Total a	amount of com	missions paid		(b) Total amou	unt of fees paid	
		402				0
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all pers	ons).		
		and address of the agent, broker	•		ees were paid	
GALLAGHER BENEFIT	SERVICES, IN	IC. TWO	O PIERCE PLACE, 14TH FLO SCA, IL 60143	OOR		
(b) Amount of sales ar	nd base	Fe	es and other commissions pa	aid		
commissions pa	id	(c) Amount	(d) F	Purpose		(e) Organization code
	402					3
	(a) Name	and address of the agent, broker	or other person to whom co	mmissions or fe	ees were paid	
	(**)		,			
(b) Amount of sales ar	nd base	Fe	es and other commissions pa	aid	-	
commissions pa		(c) Amount	(d) F	Purpose		(e) Organization code
						1

Schedule A (Form 5500)	2014	Page 2 - 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid	•
(a) Na	ine and address of the agent, broke	er, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	T
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(0)	(5)	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(4)	and and address of the agent, protect	n, et estici person to mism commissions et rece maio paid	
(h) Amount of a deal and have		Fees and other commissions paid	(-) () (
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	ridual contract	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70/4			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(3) 7e(4)			
		(4) Other (specify below)	16(4)			
		•				
		(5) Total deductions.			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

		Schedule A (Form 5500) 2014		Pa	ge 4	_	
Pa	rt II	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Whe	ere contract	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	сГ	Vision		d X Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disabilit	у д Г	Supplemental unemp	lovment	h Prescription drug
	; [Stop loss (large deductible)	j HMO contract	, s_ k□			I Indemnity contract
	' L		· 🗀	ν_	PPO Contract		I Indemnity contract
	m	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT				
<u> </u>		siana and a cuturate.					
9		erience-rated contracts: Premiums: (1) Amount received	[02/1)			_
	а	(2) Increase (decrease) in amount due but unpair		9a(1) 9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			_
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid	ſ	9b(1)		(- /	
		(2) Increase (decrease) in claim reserves	•				
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	n 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				2 (4)(1)	
		(H) Total retention	_			9c(1)(H)	
	_	(2) Dividends or retroactive rate refunds. (These	—			9c(2)	
	d	Status of policyholder reserves at end of year: (1				9d(1)	
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	
10	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	.)	9e	
IU	INC	nexperience-rated contracts:					

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	X Yes	No	

10a

10b

2681

Total premiums or subscription charges paid to carrier.....

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.....

Specify nature of costs

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

A This return/report is for:

Annual Report Identification Information

a multiemployer plan;

a single-employer plan;

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

For calendar plan year 2014 or fiscal plan year beginning

Part I

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.

05/01/2014

a DFE (specify) _

and ending

a multiple-employer plan (Filers checking this box must attach a list of

participating employer information in accordance with the form instructions); or

OMB Nos. 1210-0110 1210-0089

Form 5500 (2014) v. 140124

2014

This Form is Open to Public Inspection

04/30/2015

B This ret	urn/report is:	the first return/report;	the final retur	n/report;	
		an amended return/report;	a short plan y	rear return/report (les	ss than 12 months).
C If the pl	an is a collectively-barga	ined plan, check here			
_	box if filing under:	Form 5558;	automatic ext		the DFVC program;
		special extension (enter descriptio	, -		
Part II	Basic Plan Info	ormation—enter all requested informa	ation		
1a Name Tri-	of plan	LLC Welfare Benefits P.			1b Three-digit plan number (PN) ▶ 501
000000012003			20.2000 TO MITTHEW TO SERVE THE SERV		1c Effective date of plan 01/01/2004
	ponsor's name and addr Med Ambulance,	ress; include room or suite number (emp LLC	ployer, if for a single-	employer plan)	2b Employer Identification Number (EIN) 91-1993087
1882	1 East Valley	Hwy			2c Plan Sponsor's telephone number (888) 448-1232
Kent PO B	ox 58250		WA	98032	2d Business code (see instructions) 621900
Seat	tle		WA	98138	
C					
Under nen	alties of periury and other	incomplete filing of this return/report negatives set forth in the instructions	I declare that I have	unless reasonable o	cause is established. /report, including accompanying schedules,
statements	and attachments, as we	ell as the electronic version of this return	n/report, and to the b	est of my knowledge	and belief, it is true, correct, and complete.
SIGN HERE	K. Magg	al	10/21/15	Kari M	laggard
neke s	Signature of plan admir	nistrator	Date	Enter name of indi	vidual signing as plan administrator
SIGN HERE	K. Magy	zil	10/21/15	Kari	Maggard
	Signature of employer/	plan sponsor	Date	Enter name of indi	vidual signing as employer or plan sponsor
SIGN HERE					
	Signature of DFE		Date	Enter name of indi	vidual signing as DFE
Preparers	name (including firm ha	me, if applicable) and address (include	room or suite numbe	r) (optional)	Preparer's telephone number (optional)

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-	2	~	e	,
	u	ч	6	-

3a	Plan administrator's name and address Same as Plan Sponsor	3b Adn	ninistrator's EIN
			ninistrator's telephone nber
		1.	3
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:	4b EIN	1
а	Sponsor's name	4c PN	
5	Total number of participants at the beginning of the plan year	5	182
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1	Total number of active participants at the beginning of the plan year	6a(1)	180
a(2	2) Total number of active participants at the end of the plan year	6a(2)	142
b	Retired or separated participants receiving benefits	6b	1
С	Other retired or separated participants entitled to future benefits	6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.	6d	143
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e.	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	. 6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were	Ch.	
7	less than 100% vested Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	6h	
	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Code If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Code 4A 4B 4D 4E 4L		
9a	Plan funding arrangement (check all that apply) (1)	insuranc	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the nun		ched. (See instructions)
а	Pension Schedules b General Schedules		
	(1) R (Retirement Plan Information) (1) H (Financial Information)	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (4) I (Financial Information) - C (Service Provided Information)	mation – s rmation)	\$0.0000
voi en voi	(3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participat Information) - signed by the plan actuary (6) G (Financial Tran		

	-	1004 4
Form	2200	(2014)

Page 3

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
2520, 101-2.)	n provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR
11b Is the pl	an currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
enter the Rec	Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, eipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)
	mation Code