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 Ide	entification Information					
For cale	For calendar plan year 2014 or fiscal plan year beginning 07/01/2014 and ending 06/30/2015						
A This	eturn/report is for:	a multiemployer plan;		nployer plan (Filers checking t employer information in accor			ons); or
		x a single-employer plan;	a DFE (spec	rify)			
R This	eturn/report is:	the first return/report;	the final retu	rn/report;			
5 11115	ctam/report is.	an amended return/report;	a short plan	year return/report (less than 1	2 month	months)	
C If the	If the plan is a collectively-bargained plan, check here.						
			_	<u>-</u>	_	' ∐	
D Chec	k box if filing under:	Form 5558;	automatic ex	itension;	the DF	FVC program;	
		special extension (enter descrip	,				
Part		rmation—enter all requested info	rmation				ı
	ie of plan OVIDENCE CENTER WEL	EARE MARRIAN			1b	Three-digit plan number (PN) ▶	503
INE PR	OVIDENCE CENTER WEL	.FARE WRAP PLAN			1c	Effective date of plant	I an
						02/01/1992	 .
2a Plar	sponsor's name and addre	ess; include room or suite number (e	employer, if for a single	-employer plan)	2b	Employer Identifica	ition
THE PR	OVIDENCE CENTER					Number (EIN) 05-0316969	
					20	Plan Sponsor's tele	anhone
					20	number	priorie
	RTH MAIN STREET, 4TH F ENCE, RI 02904		LOOR IDENCE, RI 02904			401-276-4000)
TROVIE	LIVOL, IXI 02004	TROVI	DENOE, RI 02004		2d	Business code (see	Э
						instructions) 621420	
Caution	A penalty for the late or	incomplete filing of this return/re	port will be assessed	unless reasonable cause is	s establis	shed.	
		r penalties set forth in the instruction					dules,
statemer	nts and attachments, as we	ell as the electronic version of this ret	turn/report, and to the b	pest of my knowledge and bel	ief, it is tr	rue, correct, and com	nplete.
SIGN HERE	Filed with authorized/valid	electronic signature.	10/27/2015	ROSEMARY MEDE			
IIEKE	Signature of plan admin	nistrator	Date	Enter name of individual si	gning as	plan administrator	
SIGN HERE							
IIEKE	Signature of employer/p	olan sponsor	Date	Enter name of individual si	gning as	employer or plan sp	onsor
SIGN HERE							
Signature of DFE Date Enter name of individual signing							
Preparei	's name (including firm nam	me, if applicable) and address (include	de room or suite numbe		eparer's t ptional)	telephone number	
				(O)	piloriai)		

Form 5500 (2014) Page **2**

	Plan administrator's name and address Same as Plan Sponsor					ninistrator's EIN
	E PROVIDENCE CENTER					inistrator's telephone
	O NORTH MAIN STREET OVIDENCE, RI 02904				num	nber 401-528-0159
4	If the name and/or EIN of the plan sponsor has changed since the last return/re EIN and the plan number from the last return/report:	eport filed fo	or this p	plan, enter the name,	4b EIN	
а	Sponsor's name				4c PN	
5	Total number of participants at the beginning of the plan year				5	507
6	Number of participants as of the end of the plan year unless otherwise stated (6a(2), 6b, 6c, and 6d).	(welfare plan	ns com	plete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year				6a(1)	507
a(2	Total number of active participants at the end of the plan year				6a(2)	557
b	Retired or separated participants receiving benefits				. 6b	0
С	Other retired or separated participants entitled to future benefits				. 6с	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.				. 6d	557
е	Deceased participants whose beneficiaries are receiving or are entitled to receive	eive 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 (or complete this item)	-			. 6g	
h	Number of participants that terminated employment during the plan year with a less than 100% vested				. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only mu				. 7	
b	If the plan provides pension benefits, enter the applicable pension feature codes If the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4B 4D 4H 4Q	s from the Li	ist of P	an Characteristics Code	es in the ins	
9a	Plan funding arrangement (check all that apply) (1)	9b Plan be (1)	enefit a	rrangement (check all th Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Ĥ	Code section 412(e)(3)	insurance	contracts
	(3) Trust	(3)		Trust		
40	(4) X General assets of the sponsor	(4)	. X	General assets of the s	<u> </u>	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are atta	ached, and, v	where	indicated, enter the num	ber attach	ed. (See instructions)
а	Pension Schedules	b Genera	al Sch	edules		
	(1) R (Retirement Plan Information)	(1)		H (Financial Inform	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)		I (Financial Inform		mall Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)	X	6 A (Insurance Info	,	
	,	(4) (5)	H	C (Service ProvidD (DFE/Participat		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)	H	G (Financial Trans	-	
	, , , , , , , , , , , , , , , , , , , ,			,		•

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

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

rension benefit dualarity of	rporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				
For calendar plan year 20	14 or fiscal pla	n year beginning 07/01/2014	and er	oding 06/30/2015		
A Name of plan THE PROVIDENCE CENT	TER WELFARI	E WRAP PLAN		e-digit number (PN)	503	
C Plan sponsor's name as shown on line 2a of Form 5500 THE PROVIDENCE CENTER D Employer Identification Number (EIN) 05-0316969						
on a separat		ning Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
LIFE INSURANCE COM	PANY OF NOF	RTH 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	
23-1503749	65498	OK 963486	557	07/01/2014	06/30/2015	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	I commissions paid. List in line 3	the agents, brokers, and	d other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
		888			0	
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all persons).			
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid		
STARKWEATHER & SH	EPLEY		OX 549 IDENCE, RI 02901			
		Face	and other commissions paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpos	(e) Organization code		
	888		, ,		3	
(a) Name and address of the areast broken as other person to whom commissions as feed were noid						
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code	
	A 4 N1 41	LOND O. (LNL L				

Schedule A (Form 5500)	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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Par	t II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each carrier	may be treated as a unit f	for purposes of
4 C	urrer	nt value of plan's interest under this contract in the general account at year	end	4	
5 C	Currer	nt value of plan's interest under this contract in separate accounts at year e	nd	5	
6 C	ontra	acts With Allocated Funds:			
a	a 5	State the basis of premium rates			
k	c	Premiums paid to carrier		6b	
C	_	Premiums due but unpaid at the end of the year		6c	
C	r	f the carrier, service, or other organization incurred any specific costs in contract or policy, enter amount.	•	6d	
	5	Specify nature of costs			
e		Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
	fι	f contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 C	ontra	acts With Unallocated Funds (Do not include portions of these contracts ma	nintained in separate accounts)		
8	a T	Γype of contract: (1) ☐ deposit administration (2) ☐ immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
ł	o E	Balance at the end of the previous year		7b	0
		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)	0
	- `	otal of balance and additions (add lines 7b and 7c(6)).		7d	0
		eductions:			
		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)		
	(-	The state of the s	13(1)		
	,	•			
				_ (5)	
	,	5) Total deductions		7e(5)	0

Schedule A (Form 5500) 2014		Page	4	
Welfare Benefit Contract Informal If more than one contract covers the same ginformation may be combined for reporting the entire group of such individual contracts	group of employees of the sa ourposes if such contracts a	re experience-	rated as a unit. Where contrac	1) ()
efit and contract type (check all applicable boxes)			
Health (other than dental or vision)	b Dental	c \	/ision	d Life insurance
Temporary disability (accident and sickness)	f Long-term disability	, g∏s	Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	- =	PPO contract	I Indemnity contract
Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT			
_				_
erience-rated contracts:	F			
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpa	id	9a(2)		
(3) Increase (decrease) in unearned premium re	serve	9a(3)		
(4) Earned ((1) + (2) - (3))	_		9a(4)	
Benefit charges (1) Claims paid		9b(1)	•	
(2) Increase (decrease) in claim reserves				
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged				
Remainder of premium: (1) Retention charges (
(A) Commissions	′ -	9c(1)(A)		

9c(1)(H)

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

5919

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

10 Nonexperience-rated contracts:

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision)

Experience-rated contracts:

m X Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT

a Premiums: (1) Amount received...... (2) Increase (decrease) in amount due but unpaid.....

(B) Administrative service or other fees.....

(C) Other specific acquisition costs (D) Other expenses.....

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

(H) Total retention..... (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.).....

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

Part III

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

9c(1)(B) 9c(1)(C)

9c(1)(D) 9c(1)(E)

9c(1)(F)

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).	omation		Inspection
For calendar plan year 20	14 or fiscal pla	an year beginning 07/01/2014	i a	and ending 06	5/30/2015	
A Name of plan THE PROVIDENCE CENTER WELFARE WRAP PLAN			В	Three-digit plan number (P	N) •	503
C Plan sponsor's name as shown on line 2a of Form 5500 THE PROVIDENCE CENTER D Employer Identification Number (EIN) 05-0316969					(EIN)	
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
DELTA DENTAL OF RHO	ODE ISLAND					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate numbe persons covered at end		Policy or co	ontract year
(b) EIN	code	identification number	policy or contract year	· /+\	From	(g) To
05-0296998	55301	3796-0001	830	07/01/20)14	06/30/2015
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. List in	line 3 the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		7314				0
3 Persons receiving com		fees. (Complete as many entrie		•		
STARKWEATHER & SHI	· · ·	and address of the agent, broke	r, or other person to whom cor CATAMORE BOULEVARD	mmissions or fees	were paid	
STARRWEATHER & SHI	EFLET		T PROVIDENCE, RI 02914			
(b) Amount of sales ar	nd base	Fe	ees and other commissions pa	id		
commissions pa		(c) Amount	(d) P	(d) Purpose		(e) Organization code
7314						3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales ar	nd base	Fe	ees and other commissions pa	id		
commissions pa		(c) Amount	(d) P	urpose		(e) Organization code
						1

Schedule A (Form 5500)	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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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each carrier	may be treated as a unit f	for purposes of
4 C	urrer	nt value of plan's interest under this contract in the general account at year	end	4	
5 C	Currer	nt value of plan's interest under this contract in separate accounts at year e	nd	5	
6 C	ontra	acts With Allocated Funds:			
a	a 5	State the basis of premium rates			
k	c	Premiums paid to carrier		6b	
C	_	Premiums due but unpaid at the end of the year		6c	
C	r	f the carrier, service, or other organization incurred any specific costs in contract or policy, enter amount.	•	6d	
	5	Specify nature of costs			
e		Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
	fι	f contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 C	ontra	acts With Unallocated Funds (Do not include portions of these contracts ma	nintained in separate accounts)		
8	a T	Γype of contract: (1) ☐ deposit administration (2) ☐ immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
ł	o E	Balance at the end of the previous year		7b	0
		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)	0
	- `	otal of balance and additions (add lines 7b and 7c(6)).		7d	0
		eductions:			
		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)		
	(-	The state of the s	13(1)		
	,	•			
				_ (5)	
	,	5) Total deductions		7e(5)	0

Page 4	
employer(s) or members of the same en xperience-rated as a unit. Where contract d as a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d ☐ Life insurance h ☐ Prescription drug l ☐ Indemnity contract
I	

Pa	art III	If more than one contract covers the same gr information may be combined for reporting puthe entire group of such individual contracts v	oup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contract		
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	у д	Supplemental unem	ployment	h Prescription dru	g
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contra	act
	m	Other (specify)	_	_			_	
9	Expe	erience-rated contracts:						
	a F	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	J					
		(3) Increase (decrease) in unearned premium res	serve	9a(3)		1		
		(4) Earned ((1) + (2) - (3))				9a(4)		C
		Benefit charges (1) Claims paid	-	. ,				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		C
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees	F	9c(1)(B)				
		(C) Other specific acquisition costs	<u></u>	9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies	<u>.</u>	9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		C
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	benefits after	retirement			
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	. 9e		
10		nexperience-rated contracts:		. ,	•			
		Total premiums or subscription charges paid to c	arrier			. 10a		342216
	_	If the carrier, service, or other organization incurr						
		retention of the contract or policy, other than repo	, ,		•	10b		

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

Specify nature of costs >

Schedule A (Form 5500) 2014

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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

For calendar plan year 20	14 or fiscal plan	year beginning 07/01/2014		and en	ding 06/30/2015	
A Name of plan THE PROVIDENCE CENT	WRAP PLAN		B Three	e-digit number (PN)	503	
C Plan sponsor's name a THE PROVIDENCE CENT		2a of Form 5500		D Emplo	yer Identification Number (6969	EIN)
		ing Insurance Contract (Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
SUN LIFE ASSURANCE	COMPANY OF	CANADA				
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or co	ntract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	(g) To
38-1082080	80802	236475	43	35	07/01/2014	06/30/2015
2 Insurance fee and comp descending order of the		tion. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents, brokers, and ot	her persons in
(a) Total a	amount of comn	nissions paid		(b) To	otal amount of fees paid	
		44985				4252
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all p	persons).		
		nd address of the agent, broker,	•	m commiss	ions or fees were paid	
STARKWEATHER & SHI	EPLEY		ATAMORE BLVD PROVIDENCE, RI 029	14-1206		
(b) Amount of sales ar			s and other commission	•		
commissions pai	d 44985	(c) Amount 4252 BC		(d) Purpose	9	(e) Organization code
	44903	4232 BC	ЛИОЗ			3
	(a) Nome o	and address of the agent broker	or other person to when		iono or foco wore poid	
	(a) Name a	nd address of the agent, broker,	or other person to whor	II COMINISS	ions or rees were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose	9	(e) Organization code
	A 4 N 41	LOND O 1 IN I				

Schedule A (Form 5500) 2014 Page 2 - 1								
(a) Na	(a) Name and address of the agent, broker, 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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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each carrier	may be treated as a unit f	for purposes of
4 C	urrer	nt value of plan's interest under this contract in the general account at year	end	4	
5 C	Currer	nt value of plan's interest under this contract in separate accounts at year e	nd	5	
6 C	ontra	acts With Allocated Funds:			
a	a 5	State the basis of premium rates			
k	c	Premiums paid to carrier		6b	
C	_	Premiums due but unpaid at the end of the year		6c	
C	r	f the carrier, service, or other organization incurred any specific costs in contract or policy, enter amount.	•	6d	
	5	Specify nature of costs			
e		Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
	fι	f contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 C	ontra	acts With Unallocated Funds (Do not include portions of these contracts ma	nintained in separate accounts)		
8	a T	Γype of contract: (1) ☐ deposit administration (2) ☐ immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
ł	o E	Balance at the end of the previous year		7b	0
		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)	0
	- `	otal of balance and additions (add lines 7b and 7c(6)).		7d	0
		eductions:			
		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)		
	(-	The state of the s	13(-1)		
	,	•			
				_ (5)	
	,	5) Total deductions		7e(5)	0

Pa	age 4		
e experien	` ,	ere contracts	oloyee organizations(s), the s cover individual employees,
c [g [k [Vision Supplemental unemp PPO contract		d ☐ Life insurance h ☐ Prescription drug I ☐ Indemnity contract
00(1)			
9a(1) 9a(2)			
9a(3)		05(4)	0
9b(1)		9a(4)	0

		If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts ar	re experienc	e-rated as a unit. Wh	ere contract		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	oloyment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	t
	m	X Other (specify) ▶STOP LOSS - SPECIFIC AI	ND AGGREGATE		•			
9	Expe	erience-rated contracts:						
-	•	Premiums: (1) Amount received	Г	9a(1)			-	
		(2) Increase (decrease) in amount due but unpai	_	9a(2)			-	
		(3) Increase (decrease) in unearned premium res		9a(3)			=	
		(4) Earned ((1) + (2) - (3))	_			9a(4)		(
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves	<u> </u>	9b(2)			1	
		(3) Incurred claims (add (1) and (2))	<u> </u>			9b(3)		(
		(4) Claims charged				9b(4)		
	С	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)]	
		(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	e amounts were paid in o	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide be	enefits after	retirement			
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered i	n line 9c(2) .	.)	9e		
10) No	onexperience-rated contracts:		•		•		
	а	Total premiums or subscription charges paid to	carrier			10a	,	449854
	b	If the carrier, service, or other organization incur	red any specific costs in cor	nnection wit	h the acquisition or			
		retention of the contract or policy, other than rep	orted in Part I, line 2 above,	, report amo	unt	10b		

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

Specify nature of costs

Schedule A (Form 5500) 2014

Part III Welfare Benefit Contract Information

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).	mation		Inspection	
For calendar plan year 20	14 or fiscal pla	an year beginning 07/01/2014	an	d ending 06/30	/2015		
A Name of plan THE PROVIDENCE CENT	ΓER WELFAR	RE WRAP PLAN		Γhree-digit plan number (PN)	•	503	
C Plan sponsor's name a THE PROVIDENCE CENT		ne 2a of Form 5500		mployer Identification i-0316969	on Number (EIN)	
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
THE LIFE INSURANCE (COMPANY OF	F NORTH AMERICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	.f	Policy or co		
(5) EIIV	code	identification number	policy or contract year	" (f) Fr	rom	(g) To	
23-1503749	65498	FLX961901	557	07/01/2014		06/30/2015	
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. List in lin	ne 3 the agents, bro	okers, and ot	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
2490							
3 Persons receiving com		fees. (Complete as many entrie					
STARKWEATHER & SHI		and address of the agent, broke	r, or other person to whom commatter commerce. CATAMORE BOULEVARD	missions or fees we	ere paid		
STARRWEATHER & SHI	EPLET		T PROVIDENCE, RI 02914				
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpose			(e) Organization code	
	2490					3	
	(-) N	and address of the arrest banks					
	(a) Name	and address of the agent, broke	r, or other person to whom com	missions or fees we	ere paid		
			one and other commissions ==:-				
(b) Amount of sales ar commissions pa		(c) Amount	ees and other commissions paid (d) Pur			(e) Organization code	
		,,	(-)/	•		, , ,	

Schedule A (Form 5500)	2014	Page 2 - 1					
(a) Na	(a) Name and address of the agent, broker, 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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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	may be treated as a unit f	for purposes of				
4 C	urrer	nt value of plan's interest under this contract in the general account at year	end	4				
5 C	Currer	nt value of plan's interest under this contract in separate accounts at year e	nd	5				
6 C	Contracts With Allocated Funds:							
a	a 5	State the basis of premium rates						
k	c	Premiums paid to carrier		6b				
C	_	Premiums due but unpaid at the end of the year		6c				
C	r	f the carrier, service, or other organization incurred any specific costs in contract or policy, enter amount.	•	6d				
	5	Specify nature of costs						
e		Type of contract: (1) individual policies (2) group deferred	d annuity					
	(3) other (specify)						
	fι	f contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here					
7 C	ontra	acts With Unallocated Funds (Do not include portions of these contracts ma	nintained in separate accounts)					
8	a T	Γype of contract: (1) ☐ deposit administration (2) ☐ immedia	ate participation guarantee					
		(3) guaranteed investment (4) other						
ł	o E	Balance at the end of the previous year		7b	0			
		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)	0			
	- `	otal of balance and additions (add lines 7b and 7c(6)).		7d	0			
		eductions:						
		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)					
	(-	The state of the s	13(-1)					
	,	•						
				_ (5)				
	,	5) Total deductions		7e(5)	0			

Page 4	
e employer(s) or members of the same experience-rated as a unit. Where conduct as a unit for purposes of this report	ontracts cover individual employee
c ☐ Vision g ☐ Supplemental unemploym k ☐ PPO contract	d X Life insurance ent h Prescription drug I Indemnity contract
a(1)	
(1)	

Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts w	oup of employees of the urposes if such contracts	are experience	ce-rated as a unit. Wh	ere contract		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment	h Prescription drug	
	i [Stop loss (large deductible)	j	, G_	<u>.</u>	•	I Indemnity contract	
	m	Other (specify)	,	L	1		- L	
9	Ехре	erience-rated contracts:						
	а	Premiums: (1) Amount received						
		(2) Increase (decrease) in amount due but unpaid	l					
		(3) Increase (decrease) in unearned premium res	erve	. 9a(3)		1		
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves				21.42		
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	,	0.(4)(4)				
		(A) Commissions						
		(B) Administrative service or other fees					_	
		(C) Other specific acquisition costs		- (1)(-)			_	
		(D) Other expenses		2 (4)(5)			_	
		(E) Taxes		0 (4)(5)			_	
		(F) Charges for risks or other contingencies (G) Other retention charges					_	
		(H) Total retention(H)				9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These		_				0
	٦	Status of policyholder reserves at end of year: (1				9c(2)		
	d	(2) Claim reserves	•			9d(1)		
		• •				9d(2)		
	_	(3) Other reserves Dividends or retroactive rate refunds due. (Do no				9d(3) 9e		
10		onexperience-rated contracts:	ot include amount entered		.)	96		
10		Total premiums or subscription charges paid to c	arrior			10a	20	9593
	a b	If the carrier, service, or other organization incurr				Iva	28	1093
		retention of the contract or policy, other than repo	, ,		•	10b		
	Sp	pecify nature of costs						

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

Schedule A (Form 5500) 2014

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).	maion	Inspection	
For calendar plan year 20	14 or fiscal pla	an year beginning 07/01/2014	an	d ending 06/30/	/2015	
A Name of plan THE PROVIDENCE CENT	A Name of plan THE PROVIDENCE CENTER WELFARE WRAP PLAN			Three-digit plan number (PN)	503	
C Plan sponsor's name as shown on line 2a of Form 5500 THE PROVIDENCE CENTER D Employer Identification Number (E 05-0316969					on Number (EIN)	
		rning Insurance Contract Individual contracts grouped a			ovide information for each contract le Schedule A.	
1 Coverage Information:						
(a) Name of insurance ca	rrier					
LIFE INSURANCE COMP	PANY OF NO	RTH AMERICA				
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of		Policy or contract year	
(b) EIN	code	identification number	policy or contract year	(f) Fro	om (g) To	
23-1503749	65498	LK 961448	459	07/01/2014	06/30/2015	
	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						
	4671 0					
3 Persons receiving com		fees. (Complete as many entrie				
STARKWEATHER & SHE		and address of the agent, broke	r, or other person to whom comr CATAMORE BOULEVARD	missions or fees we	ere paid	
			ST PROVIDENCE, RI 02914			
(b) Amount of sales ar	nd base		ees and other commissions paid			
commissions pai		(c) Amount	(d) Pur	pose	(e) Organization code	
	4671				3	
	(a) Nama	and addrage of the agent broke	r or other person to whom come	missions or foos wo	are poid	
	(a) Name	and address of the agent, broke	i, or other person to whom com	Tilssions of fees we	ere paid	
(b) Amount of sales ar	nd base	Fe	ees and other commissions paid			
commissions pai		(c) Amount	(d) Pur	pose	(e) Organization code	

Schedule A (Form 5500)	2014	Page 2 - 1					
(a) Na	(a) Name and address of the agent, broker, 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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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	may be treated as a unit f	for purposes of				
4 C	urrer	nt value of plan's interest under this contract in the general account at year	end	4				
5 C	Currer	nt value of plan's interest under this contract in separate accounts at year e	nd	5				
6 C	Contracts With Allocated Funds:							
a	a 5	State the basis of premium rates						
k	c	Premiums paid to carrier		6b				
C	_	Premiums due but unpaid at the end of the year		6c				
C	r	f the carrier, service, or other organization incurred any specific costs in contract or policy, enter amount.	•	6d				
	5	Specify nature of costs						
e		Type of contract: (1) individual policies (2) group deferred	d annuity					
	(3) other (specify)						
	fι	f contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here					
7 C	ontra	acts With Unallocated Funds (Do not include portions of these contracts ma	nintained in separate accounts)					
8	a T	Γype of contract: (1) ☐ deposit administration (2) ☐ immedia	ate participation guarantee					
		(3) guaranteed investment (4) other						
ł	o E	Balance at the end of the previous year		7b	0			
		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)	0			
	- `	otal of balance and additions (add lines 7b and 7c(6)).		7d	0			
		eductions:						
		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)					
	(-	The state of the s	13(1)					
	,	•						
				_ (5)				
	,	5) Total deductions		7e(5)	0			

Schedule A (Form 5500) 2014		Page 4	
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 sam urposes if such contracts are	experience-rated as a unit. Where contra	. , .
and contract type (check all applicable boxes))		
lealth (other than dental or vision)	b Dental	c Vision	d Life insurance
emporary disability (accident and sickness)	f X Long-term disability	g Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k ☐ PPO contract	I Indemnity contract
Nih and January 18 A			

8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term disability	g	Supplemental unemp	oloyment	h Prescription drug	
	i į	Stop loss (large deductible)	j HMO contract	~ =	PPO contract	·	I Indemnity contract	
	m	Other (specify)	, <u>.</u>	_				
9	Ехре	erience-rated contracts:						
	a I	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	d	9a(2)				
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	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)		0
		(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (o	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		9c(1)(G)				
		(H) Total retention				9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)						
	d	Status of policyholder reserves at end of year: (1	—	<u></u>		9c(2) 9d(1)		
		(2) Claim reserves	· •			9d(2)		
		(3) Other reserves.						
	е	Dividends or retroactive rate refunds due. (Do no				9d(3) 9e		
10		nexperience-rated contracts:		(-)	,			
		Total premiums or subscription charges paid to o	arrier			10a		67142
		If the carrier, service, or other organization incur						
		retention of the contract or policy, other than repo				10b		
	Sp	pecify nature of costs						

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

Part III

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).	ation	Inspection
For calendar plan year 20	14 or fiscal pla	an year beginning 07/01/2014	and e	ending 06/30/2015	
A Name of plan THE PROVIDENCE CENT	TER WELFAR	E WRAP PLAN		ee-digit n number (PN)	503
C Plan sponsor's name a THE PROVIDENCE CENT		ne 2a of Form 5500		loyer Identification Number 316969	er (EIN)
			Coverage, Fees, and Cons a unit in Parts II and III can be re		
1 Coverage Information:		·		Ţ.	
(a) Name of insurance ca	rrier				
DELTA DENTAL OF RHO	ODE ISLAND				
/L) [IN]	(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
05-0296998	55301	37962	10	07/01/2014	06/30/2015
2 Insurance fee and com descending order of the			otal commissions paid. List in line	3 the agents, brokers, and	other persons in
(a) Total a	amount of con	nmissions paid	(b) ⁻	Total amount of fees paid	
_		78			0
3 Persons receiving com			s as needed to report all persons).		
STARKWEATHER & SH			r, or other person to whom commis	ssions or fees were paid	
OTATION EXTENSION	LI LLI IIIO		T PROVIDENCE, RI 02914		
(b) Amount of sales ar	nd base	Fe	es and other commissions paid		
commissions pa	id	(c) Amount	(d) Purpo	se	(e) Organization code
	78				3
	(a) Name	and address of the agent, broker	r, or other person to whom commis	ssions or fees were paid	
	• •		·		
(b) Amount of sales ar			es and other commissions paid		
commissions pa	id	(c) Amount	(d) Purpo	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	
	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

		•
חבי	Δ	- 5
ay	v	•

Par	t II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each carrier	may be treated as a unit f	for purposes of
4 C	urrer	nt value of plan's interest under this contract in the general account at year	end	4	
5 C	Currer	nt value of plan's interest under this contract in separate accounts at year e	nd	5	
6 C	ontra	acts With Allocated Funds:			
a	a 5	State the basis of premium rates			
k	c	Premiums paid to carrier		6b	
C	_	Premiums due but unpaid at the end of the year		6c	
C	r	f the carrier, service, or other organization incurred any specific costs in contract or policy, enter amount.	•	6d	
	5	Specify nature of costs			
e		Type of contract: (1) individual policies (2) group deferred	d annuity		
	(3) other (specify)			
	fι	f contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 C	ontra	acts With Unallocated Funds (Do not include portions of these contracts ma	nintained in separate accounts)		
8	a T	Γype of contract: (1) ☐ deposit administration (2) ☐ immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
ł	o E	Balance at the end of the previous year		7b	0
		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)	0
	- `	otal of balance and additions (add lines 7b and 7c(6)).		7d	0
		eductions:			
		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)		
	(-	The state of the s	13(1)		
	,	•			
				_ (5)	
	,	5) Total deductions		7e(5)	0

Schedule A (Form 5500) 2014		Page 4	
Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting put the entire group of such individual contracts of the same guinformation may be combined for reporting put the entire group of such individual contracts of the same guinformation in the same guinformation	roup of employees of the same urposes if such contracts are e	experience-rated as a unit. Where contra	
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	b X Dental	C Vision	d Life insurance
emporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug
top loss (large deductible)	j HMO contract	k PPO contract	I Indemnity contract

	e	Temporary disability (accident and sickness) f Long-term	n disability g	Supplemental unemp	loyment h	Prescription drug	
	iΓ	Stop loss (large deductible) j HMO con	tract k	PPO contract	I	Indemnity contract	
	m	Other (specify)	_	1			
	···· [Other (specify)					
) E	Ехре	erience-rated contracts:					
		Premiums: (1) Amount received	9a(1)				
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium reserve					
		(4) Earned ((1) + (2) - (3))			9a(4)		0
	b	Benefit charges (1) Claims paid			. ,		
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))			9b(3)		0
		(4) Claims charged			9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual bas	is)	•	, ,		
		(A) Commissions					
		(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	0 (4)(0)				
		(H) Total retention			9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to			9d(1)		
		(2) Claim reserves	•		9d(2)		
		(3) Other reserves			9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amoun			9e		
0	No	nexperience-rated contracts:	()	,			
	а	Total premiums or subscription charges paid to carrier			10a		3530
	b	If the carrier, service, or other organization incurred any specific of					
		retention of the contract or policy, other than reported in Part I, lin			10b	1	

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

Specify nature of costs

8 Benefit and contract type (check all applicable boxes) **a** Health (other than dental or vision)

Part III

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

Form 5500

Department of the Treasury Internal Revenue Service

> Department of Labor Employee Benefits Security Administration

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

Pension Benefit Gearanty Corporation				This Form is Open to Public Inspection
Part I Annual Report Id	entification Information			
For calendar plan year 2014 or fisc	al plan year beginning 07/01/2	014	and ending 0	6/30/2015
A This return/report is for:	a multiemployer plan;		mployer information in ac	ng this box must attach a list of ecordance with the form instructions); or
B This return/report is:	the first return/report;	the final return	n/report;	
•	an amended return/report;	a short plan y	ear return/report (less tha	an 12 months).
C If the plan is a collectively-barga	nined plan, check here			
D Check box if filing under:	Form 5558;	automatic exte	ension;	the DFVC program;
	special extension (enter description	n)		
1	rmation—enter all requested informa	ition		
1a Name of plan	TER WELFARE WRAP PLAN			1b Three-digit plan number (PN) > 503
THE TROVIDENCE CEN	THE MEDITARIE WEST LEAVE			1c Effective date of plan 02/01/1992
2a Płan sponsor's name and addr The Providence Cen	ess; include room or suite number (emp ter	loyer, if for a single-	employer plan)	2b Employer Identification Number (EIN) 05-0316969
530 North Main Str	eet, 4th Floor 4TH	FLOOR		2c Plan Sponsor's telephone number 401-276-4000
Providence	RI 02904 PROV	IDENCE	RI 02904	2d Business code (see instructions) 621420
				,
Caution: A penalty for the late or	incomplete filing of this return/repor	t will be assessed u	ınless reasonable caus	e is established.
Under penalties of perjury and other	er penalties set forth in the instructions, l ell as the electronic version of this return	declare that I have a	examined this return/repo	rt, including accompanying schedules,
SIGN ON	e	10/7/15	Rosemary Mede	
HERE Signature of plan admir	nistrator	Date	Enter name of individua	al signing as plan administrator
SIGN RE M	ede .	10/7/15	Rosemary Mede	
HERE Signature of employer/	plan sponsor	Date	Enter name of individua	al signing as employer or plan sponsor
SIGN HERE				
Signature of DFE		Date	Enter name of Individua	
Preparer's name (including firm na	me, if applicable) and address (include r	room or suite number) (optional)	Preparer's telephone number (optional)

3a	The summand of the sum		ninistrator's EIN 05-0316969
	THE PROVIDENCE CENTER		ninistrator's telephone
	530 NORTH MAIN STREET		nber 01-528-0159
	PROVIDENCE RI 02904		
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	<u> </u>
а	Sponsor's name	4c PN	
5	Total number of participants at the beginning of the plan year	5	507
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)	507
a(2	2) Total number of active participants at the end of the plan year	6a(2)	557
b	Retired or separated participants receiving benefits	6b	0
С	Other retired or separated participants entitled to future benefits	6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.	6d	557
ę	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 less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
b	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 Codes $4A$ $4B$ $4D$ $4H$ $4Q$	in the in	
9a	Plan funding arrangement (check all that apply) (1)	t apply)	
	(2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) i	nsurance	e contracts
	(3) Trust (3) Trust	onace	
10	(4) X General assets of the sponsor (4) X General assets of the sp		ned. (See instructions)
	a Pension Schedules b General Schedules		
C	(1) R (Retirement Plan Information) (1) H (Financial Inform	ration)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money (2) 1 (Financial Inform	•	Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan (3) X 6 A (Insurance Information)	mation)	•
	actuary (4) C (Service Provide		•
	(3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Information) - signed by the plan actuary (6) G (Financial Trans	-	·

Form	<u> ዳ</u> ዳበቤ	(2014)
COMM	JJUU	12014

Page 3

Part III	Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)					
	an provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR					
If "Yes" is che	ecked, complete lines 11b and 11c.					
11b Is the p	an currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520,101-2.)					
enter the Rec	e 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, relpt 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.)					
Receipt Confi	irmation Code					