#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

Part I	Annual Report Id	lentification Information		•				
For caler	ndar plan year 2016 or fisc	al plan year beginning 01/01/2016		and ending 12/31/2016				
A This r	eturn/report is for:	a multiemployer plan		ployer plan (Filers checking this employer information in accordar			ons.)	
		x a single-employer plan	a DFE (specify)					
<b>B</b> This r	eturn/report is:	the first return/report	the final return	the final return/report				
		an amended return/report	a short plan y	ear return/report (less than 12 m	onths	)		
C If the	plan is a collectively-barga	ained plan, check here				<b>•</b>		
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exte	nsion	th	e DFVC program		
·		special extension (enter description	n)					
Part II	Basic Plan Inforr	nation—enter all requested informa	tion					
	e of plan LIFE, AD&D AND DISAB	ILITY PLANS FOR THE EMPLOYEES	S OF PEDIATRIC HO	ME SERVICE	1b	Three-digit plan number (PN) ▶	503	
					1c	Effective date of p 01/01/1996	lan	
Maili	ng address (include room,	er, if for a single-employer plan) , apt., suite no. and street, or P.O. Box country, and ZIP or foreign postal coo		ructions)	2b	Employer Identification Number (EIN) 41-1656511	ation	
PEDIATRIC HOME RESPIRATORY SERVICES INC. PEDIATRIC HOME SERVICE					2c Plan Sponsor's telephone number 651-604-5183			
2800 CLEVELAND AVENUE NORTH ROSEVILLE, MN 55113  2800 CLEVELAND AVENUE NORTH ROSEVILLE, MN 55113				NORTH	2d Business code (see instructions) 621610		ee	
Caution	Δ nenalty for the late or	incomplete filing of this return/rep	ort will be assessed	unless reasonable cause is e	etabli	shad		
Under pe	enalties of perjury and other	er penalties set forth in the instructions	s, I declare that I have	examined this return/report, inc	luding	accompanying sche		
statemer	ns and attachments, as we	ell as the electronic version of this retu	In/report, and to the t	The stormy knowledge and belief	, it is ti	rue, correct, and cor	пріете.	
SIGN	Filed with authorized/valid	Lologtronia gianatura	07/07/2017	JENNIE BUETTNER				
HERE		-	07/07/2017			alan adadatatata		
	Signature of plan admi	nistrator	Date	Enter name of individual sign	ing as	pian administrator		
SIGN								
HERE	Signature of employer/	plan sponsor	Date	Enter name of individual sign	ing as	employer or plan sp	onsor	
SIGN HERE								
Signature of DFE Date Enter name of individual signin								
Preparer	's name (including firm na	me, if applicable) and address (include	e room or suite numbe	er) Prepa	arer's	telephone number		

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### If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, and he plan number from the last return/report. All plan of the plan number from the last return/report. All plan of the plan number from the last return/report. All plan of the plan number from the last return/report. All plan of the plan number of participants at the beginning of the plan year	3a	Plan administrator's name and address X Same as Plan Sponsor	<b>3b</b> Administrator's EIN		
Sponsor's name   Spon					
Sponsor's name   Spon					
Total number of participants at the beginning of the plan year  Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), aa(1) Total number of active participants at the beginning of the plan year  (aa(2) Total number of active participants at the edin of the plan year  (aa(2) Total number of active participants at the end of the plan year  (aa(2) Total number of active participants at the end of the plan year  (aa(2) Total number of active participants at the end of the plan year  (aa(2) Total number of active participants receiving benefits.  (b) Retired or separated participants receiving benefits.  (c) Other retired or separated participants entitled to future benefits  (d) Subtotal. Add lines 6a(2), 6b, and 6c.  (e) Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.  (e) Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.  (e) Deceased participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  (f) Number of participants with account balances as of the end of the plan year with accrued benefits that were less than 100% vested  (as an 100% vested  (b) If the plan provides welfare benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  (a) If the plan provides welfare benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  (a) Insurance  (b) If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  (a) Insurance  (b) Insurance  (c) Code section 412(e)(3) insurance contracts  (d) Code section 412(e)(3) insurance contracts  (d) Ceneral assets of the sponsor  (e) Code section 412(e)(3) insurance contracts  (f) Retirement Plan Information)  (g) MB (Multiemployer Defined Benefit Plan Actuarial  (h)	4		/report filed for this plan, enter the name,	4b EIN	
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) 236  b Retired or separated participants receiving benefits.  6 C Other retired or separated participants receiving benefits.  6 C Other retired or separated participants receiving benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants receiving or are entitled to receive benefits.  6 C Other retired or separated participants whose beneficiaries are receiving or are entitled to receive benefits.  6 P Occased participants whose beneficiaries are receiving or are entitled to receive benefits.  6 P Off Other benefits of participants whose beneficiaries are receiving or are entitled to receive benefits.  6 P Off Other benefits of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  6 P Off Other benefits 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).  7 P OTHER TOTAL PROVING SERVING SE	а	Sponsor's name		4c PN	
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	5	Total number of participants at the beginning of the plan year		<b>5</b> 307	
Retired or separated participants at the end of the plan year   Ga(2)   296	6		d (welfare plans complete only lines 6a(1),		
b Retired or separated participants receiving benefits	a(1	) Total number of active participants at the beginning of the plan year		<b>6a(1)</b> 307	
C Other retired or separated participants entitled to future benefits	a(2	Total number of active participants at the end of the plan year		<b>6a(2)</b> 296	
d Subtotal Add lines 6a(2), 6b, and 6c	b	Retired or separated participants receiving benefits		6b	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	С	Other retired or separated participants entitled to future benefits		6c	
f Total. Add lines 6d and 6e	d	Subtotal. Add lines 6a(2), 6b, and 6c	6d 296		
Solution	е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits		
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	f	Total. Add lines 6d and 6e.		6f	
less than 100% vested   Sh	g			6g	
Ba If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:    b	h			6h	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4B 4F 4H 4L  9a Plan funding arrangement (check all that apply) (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (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. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (4) B General Schedules (1) F (Financial Information) (2) C (Service Provider Information) (3) SB (Single-Employer Defined Benefit Plan Actuarial	7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer plans complete this item)	7	
(1)	b	If the plan provides welfare benefits, enter the applicable welfare feature code 4B 4F 4H 4L	les from the List of Plan Characteristics Codes	s in the instructions:	
(2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor (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. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) Trust (4) General assets of the sponsor  (1) H (Financial Information) (2) H (Financial Information – Small Plan) (3) A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	9a			at apply)	
(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. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) R (Single-Employer Defined Benefit Plan Actuarial (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)		``	<del></del>	insurance contracts	
(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. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) SB (Single-Employer Defined Benefit Plan Actuarial  (4) General assets of the sponsor  (4) General assets of the sponsor  (4) General assets of the sponsor  (5) General assets of the sponsor  (6) General assets of the sponsor  (8) General assets of the sponsor  (9) I (Financial Information – Small Plan)  (1) A (Insurance Information)  (2) C (Service Provider Information)  (3) C (Service Provider Information)				modrance contracts	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) SB (Single-Employer Defined Benefit Plan Actuarial  (5) D (DFE/Participating Plan Information)				oonsor	
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) Q SB (Single-Employer Defined Benefit Plan Actuarial (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	10		ttached, and, where indicated, enter the numb	per attached. (See instructions)	
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) Q SB (Single-Employer Defined Benefit Plan Actuarial (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	9	Pansian Schodulas	h Ganaral Schadulas		
Purchase Plan Actuarial Information) - signed by the plan actuary  (3) 4 A (Insurance Information)  C (Service Provider Information)  D (DFE/Participating Plan Information)	а			nation)	
(-)		Purchase Plan Actuarial Information) - signed by the plan	(3) A (Insurance Infor	mation)	
				-	

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
<b>11a</b> If the 2520	plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 1.101-2.)
lf "Y€	es" is checked, complete lines 11b and 11c.
<b>11b</b> Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
Rece	r the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the 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 enter a valid eipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)
Rece	eipt Confirmation Code

Form 5500 (2016)

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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

2016

This Form is Open to Public Inspection

For calendar plan year 20	16 or fiscal plar	n year beginning 01/01/2016		and er	nding 12/31/2016	-	
A Name of plan GROUP LIFE, AD&D AND DISABILITY PLANS FOR THE EMPLOYEES OF PEDIA HOME SERVICE					e-digit n number (PN)	503	
•	C Plan sponsor's name as shown on line 2a of Form 5500 PEDIATRIC HOME RESPIRATORY SERVICES INC.					(EIN)	
	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.						
Coverage Information:	ate Schedule A	. Individual contracts grouped a	as a unit in Parts II and I	ii can be re	ported on a single Schedul	e A.	
(a) Name of insurance ca		E)					
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or c	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To	
23-1503749	65498	FLX967140			01/01/2016	01/01/2017	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and o	ther persons in	
(a) Total	amount of comr	missions paid		<b>(b)</b> To	otal amount of fees paid		
		908				0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
-		nd address of the agent, broker			sions or fees were paid		
MORGAN PLANNING GRO	OUP LLC		OUTH FIFTH STREET, S EAPOLIS, MN 55402	SUITE 2300	0		
(h) Amount of color or	ad boos	Fe	es and other commissio	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount (d) Purpose		е	(e) Organization code		
908						3	
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	sions or fees were paid		
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code	
For Paperwork Reduction	on Act Notice,	see the Instructions for Form	5500.		Sche	dule A (Form 5500) 2016	

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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	Part	II Investment and Annuity Contract Information							
		Where individual contracts are provided, the entire group of such individus this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of				
		ent value of plan's interest under this contract in the general account at year		4					
		rrent value of plan's interest under this contract in separate accounts at year end							
6	Cont	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 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 terminate							
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma							
	а	Type of contract: (1) $\square$ deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee						
		(3) guaranteed investment (4) dother							
	L			71.					
	b	Balance at the end of the previous year		7b					
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)						
		(3) Interest credited during the year	7c(3)						
		(4) Transferred from separate account	7c(4)						
		(5) Other (specify below)	7c(5)						
		<b>)</b>							
		(6)Total additions		7c(6)	0				
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d					
		Deductions:	7.(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(4)						
		•	7.5(4)						
		,							
		(5) Total deductions		7e(5)	0				
	f	(5) Total deductions		76(3)					
		(00000000000000000000000000000000000000							

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Pa	art I	Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same of the information may be combined for reportional employees, the entire group of such individual.	ng purposes if such cont	racts are expe	erience-rated as a un	t. Where co	ntracts cov	
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	с□	Vision		d X Life i	insurance
	еĒ		f Long-term disabili		Supplemental unem	nlovment		cription drug
	i [	Stop loss (large deductible)	j HMO contract		PPO contract	p.0)		mnity contract
	. ∟		) [] Tilvio contract	□	11 O contract		• 🔲 шас	mility contract
	m	Other (specify)						
9 1	Evno	erience-rated contracts:						
-	•	Premiums: (1) Amount received		9a(1)			_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_	
		(3) Increase (decrease) in unearned premium rese		9a(3)			_	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	_	Benefit charges (1) Claims paid				., •(.)		
		(2) Increase (decrease) in claim reserves		21 (2)			_	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (or						
		(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						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were 🗌 paid ir	n cash, or 🗌 c	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line <b>9c(2)</b> .	)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	arrier			10a		18156
	b	If the carrier, service, or other organization incurre						
	O	retention of the contract or policy, other than repo	rted in Part I, line 2 abov	e, report amo	unt	10b		
	Spe	cify nature of costs.						
D.	art I	V Provision of Information						
				lata Calcadad	<u> </u>	Voc	V Na	
		I the insurance company fail to provide any informa		lete Schedule	A?	Yes	× No	
12	If th	ne answer to line 11 is "Yes," specify the information	on 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

2016

This Form is Open to Public Inspection

For calendar	pian year 2016	or fiscai pian	year beginning 01/01/2016		and en	iaing 12/31/2016	5						
A Name of plan GROUP LIFE, AD&D AND DISABILITY PLANS FOR THE EMPLOYEES (HOME SERVICE				OF PEDIATRIC		e-digit number (PN)	<b>)</b>	503					
C Plan sponsor's name as shown on line 2a of Form 5500 PEDIATRIC HOME RESPIRATORY SERVICES INC.  D Employer Identification Number (E						EIN)							
Part I			ning Insurance Contrac Individual contracts grouped a										
1 Coverage													
` '	insurance carri JP INSURANCE		LITY)										
(b) I	EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			•	ontract year					
		code	identification number	policy or contrac	t year	(f) From		<b>(g)</b> To					
23-1503749	6	55498	LK964900			01/01/2016		01/01/2017					
	fee and commi g order of the a		tion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, broker	rs, and o	ther persons in					
	(a) Total am	nount of comm			<b>(b)</b> To	otal amount of fees	paid						
•			2297					0					
3 Persons re	eceiving commi		es. (Complete as many entries nd address of the agent, broker	· · · · · · · · · · · · · · · · · · ·		ions or fees were	naid						
MORGAN PLA	ANNING GROU	• •	100 SC	DUTH FIFTH STREET, SEAPOLIS, MN 55402			<u>rana</u>						
					.,			T					
	int of sales and nmissions paid		(c) Amount	Fees and other commissions paid (d) Purpose				(e) Organization code					
2297					(1)			3					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid													
		(1)		, ,									
(b) Amou	ınt of sales and	base	Fe	es and other commissio	ns paid								
` '	nmissions paid		(c) Amount		(d) Purpose	e		(e) Organization code					
For Paperwo	ork Reduction	Act Notice, s	ee the Instructions for Form	5500.			Sched	For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule A (Form 5500) 2016					

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of					
		where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of		
		ent value of plan's interest under this contract in the general account at year		4			
		ent value of plan's interest under this contract in separate accounts at year e	nd	5			
6	Cont	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 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 terminate					
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma					
	а	Type of contract: (1) $\square$ deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee				
		(3) guaranteed investment (4) dother					
	L			71.			
	b	Balance at the end of the previous year		7b			
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		<b>)</b>					
		(6)Total additions		7c(6)	0		
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d			
		Deductions:	7.(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(4)				
		•	7.5(4)				
		,					
		(5) Total deductions		7e(5)	0		
	f	(5) Total deductions		76(3)			
		(00000000000000000000000000000000000000					

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P	art II					
		If more than one contract covers the same group of emplo the information may be combined for reporting purposes if employees, the entire group of such individual contracts w	such contracts are exp	perience-rated as a uni	t. Where contra	cts cover individual
8	Bene	nefit and contract type (check all applicable boxes)				
	а	Health (other than dental or vision) <b>b</b> Dental	С	Vision	d	Life insurance
	е	☐ Temporary disability (accident and sickness) <b>f</b> 💢 Long-te	rm disability <b>g</b>	Supplemental unem	ployment <b>h</b>	Prescription drug
	ιË	Stop loss (large deductible)		PPO contract	. , I[	Indemnity contract
	m	Other (specify)			- <u>L</u>	]
	∟					
9	Expe	erience-rated contracts:				
	<b>a</b> P	Premiums: (1) Amount received	9a(1)			
	(	(2) Increase (decrease) in amount due but unpaid				
	(	(3) Increase (decrease) in unearned premium reserve	9a(3)			
	(	(4) Earned ((1) + (2) - (3))	·····		9a(4)	
	b	Benefit charges (1) Claims paid	9b(1)			
	(	(2) Increase (decrease) in claim reserves	9b(2)			
	(	(3) Incurred claims (add (1) and (2))			9b(3)	
	(	(4) Claims charged			9b(4)	
	С	Remainder of premium: (1) Retention charges (on an accrual ba	, <u> </u>	T		
		(A) Commissions				
		(B) Administrative service or other fees				
		(C) Other specific acquisition costs				
		(D) Other expenses	0-(4)(5)			
		(E) Taxes				
		(F) Charges for risks or other contingencies	0 (4)(0)			
		(G) Other retention charges			0o(1)(H)	
		(H) Total retention			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These amounts were			9c(2)	
		Status of policyholder reserves at end of year: (1) Amount held	•		9d(1)	
		(2) Claim reserves			9d(2) 9d(3)	
		(3) Other reserves  Dividends or retroactive rate refunds due. (Do not include amou			9e	
10		onexperience-rated contracts:	unt entered in line 30(2	· <b>J</b> ·)······	) JE	
		Total premiums or subscription charges paid to carrier			10a	45935
		If the carrier, service, or other organization incurred any specific			100	10000
		retention of the contract or policy, other than reported in Part I, I			10b	
		ecify nature of costs.	•			
P	art I	IV Provision of Information				
		d the insurance company fail to provide any information necessar	rv to complete Schedul	е А?	Yes	No
				O / \:	. 55	
12	if th	the answer to line 11 is "Yes," specify the information not provided	a. 🕨			

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

2016

					m is Open to Public Inspection		
For calendar plan year 20	16 or fiscal pla	an year beginning 01/01/2016		and en	nding 12/31	1/2016	
A Name of plan GROUP LIFE, AD&D AND HOME SERVICE	GROUP LIFE, AD&D AND DISABILITY PLANS FOR THE EMPLOYEE				e-digit number (PN	J) •	503
C Plan sponsor's name as shown on line 2a of Form 5500 PEDIATRIC HOME RESPIRATORY SERVICES INC.  D Employer Identification Number 41-1656511						ation Number	(EIN)
	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		BILITY)					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate r				ontract year
(b) LIIV	code	identification number	persons covered at en policy or contract year		(f)	From	<b>(g)</b> To
23-1503749	65498	LK751941			01/01/2016	3	01/01/2017
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. I	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total :	amount of com	nmissions paid		<b>(b)</b> To	otal amount	of fees paid	
	0 0						
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report al	persons).			
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	е		(e) Organization code
	(a) Name	and address of the agent, broke	r. or other person to who	m commiss	ions or fees	were paid	
	(1)		,			,	
(b) Amount of sales ar	nd base	F	ees and other commission	ons paid	-	•	
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of					
		where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of		
		ent value of plan's interest under this contract in the general account at year		4			
		ent value of plan's interest under this contract in separate accounts at year e	nd	5			
6	Cont	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 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 terminate					
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma					
	а	Type of contract: (1) $\square$ deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee				
		(3) guaranteed investment (4) dother					
	L			71.			
	b	Balance at the end of the previous year		7b			
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		<b>)</b>					
		(6)Total additions		7c(6)	0		
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d			
		Deductions:	7.(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(4)				
		•	7.5(4)				
		,					
		(5) Total deductions		7e(5)	0		
	f	(5) Total deductions		76(3)			
		(00000000000000000000000000000000000000					

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Га	11	-

Pa	art I	II	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of th	tracts are expe	erience-rated as a uni	t. Where co	ontract	s cover individual
8	Bene	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	<b>b</b> Dental	С	Vision		d	Life insurance
	e >	Te	emporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unem	ployment	h∏	Prescription drug
	ιĖ	_	op loss (large deductible)	j  HMO contract	· <u> </u>	PPO contract	,	- =	Indemnity contract
	m [	_	ther (specify)	, I have contract	•• _	11000111100		•П	macming contract
9 E	=xne	rieno	ce-rated contracts:						
-	•		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpai						
			ncrease (decrease) in unearned premium res						
			arned ((1) + (2) - (3))				9a(4)		
	_	. ,	efit charges (1) Claims paid						
		(2) Ir	ncrease (decrease) in claim reserves						
			ncurred claims (add (1) and (2))				9b(3)		
			Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (	on an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies						
			(G) Other retention charges		9c(1)(G)		Т		
			(H) Total retention	<u></u>	·····		9c(1)(H)	)	
		(2) [	Dividends or retroactive rate refunds. (These	e amounts were paid i	n cash, or 📗 d	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line <b>9c(2)</b> .	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to	carrier			10a		114667
	b		e carrier, service, or other organization incur						
	C		ntion of the contract or policy, other than rep nature of costs.	orted in Part I, line 2 abor	ve, report amo	ount	10b		
Pa	art I	٧	Provision of Information						
			insurance company fail to provide any inforn	nation necessary to comm	lete Schedule	А?П	Yes	X No	 O
			nswer to line 11 is "Yes," specify the informat						
-	11 (1	. ul	iono io inici i io i co, opeony the illionna	ion 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

2016

This Form is Open to Public Inspection

v. 160205

For calendar plan year 20°	16 or fiscal plar	year beginning 01/01/2016		and er	nding 12/31/2016	-	
A Name of plan GROUP LIFE, AD&D AND DISABILITY PLANS FOR THE EMPLOYEES HOME SERVICE			OF PEDIATRIC		e-digit n number (PN)	503	
C Plan sponsor's name a					oyer Identification Numb	er (EIN)	
PEDIATRIC HOME RESP	IRATORY SER	VICES INC.		41-	1656511		
	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 car CIGNA GROUP INSURANCE		ΓAL DEATH)					
(1) FIN	(c) NAIC	(d) Contract or	(e) Approximate no		Policy or contract year		
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f) From	<b>(g)</b> To	
23-1503749	65498	OK968648			01/01/2016	01/01/2017	
2 Insurance fee and commodescending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, an	d other persons in	
(a) Total a	amount of comr	nissions paid		<b>(b)</b> To	otal amount of fees paid		
		297				0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
		nd address of the agent, broker					
MORGAN PLANNING GRO	OUP LLC		OUTH FIFTH STREET, S EAPOLIS, MN 55402	SUITE 2300	0		
<b>(b)</b> Amount of sales ar commissions pai		(c) Amount	ees and other commissions paid (d) Purpose			(a) Organization code	
commissions par	297	(C) Amount		(a) Purpos	<u>e</u>	(e) Organization code	
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	sions or fees were paid		
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code	
For Panerwork Reduction	n Act Notice.	see the Instructions for Form	5500.		Sc	hedule A (Form 5500) 2016	

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	me and address of the agent, bro	sker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

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Part		II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such individus this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of
		ent value of plan's interest under this contract in the general account at year		4	
		ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Cont	ntracts 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 the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred			
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate			
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma			
	а	Type of contract: (1) $\square$ deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee		
		(3) guaranteed investment (4) dother			
	L			71.	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	
		Deductions:	7.(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(4)		
		•	7.5(4)		
		,			
		(5) Total deductions		7e(5)	0
	f	(5) Total deductions		76(3)	
		(00000000000000000000000000000000000000			

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Pa	ırt I	III Welfare Benefit Contract Informal If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	group of employees of thing purposes if such con	tracts are expe	erience-rated as a unit	. Where co	ontracts cover inc	
<b>8</b> E	3ene	nefit and contract type (check all applicable boxes)						
;	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insura	nce
	еΓ	Temporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unem	olovment	h Prescription	on drug
i	:	Stop loss (large deductible)	j  HMO contract	· <u>- </u>	PPO contract	•	I ☐ Indemnity	-
1	m >		, I Time definition	"∟	11700011111101			ooniraat
9 E	хре	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)		1		
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		
		Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves				1		
	(	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (or	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) 9c(1)(G)			_	
		(G) Other retention charges				00(4)(U)		
		(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)		
40		Dividends or retroactive rate refunds due. (Do no	ot include amount entere	d in line 9c(2).	.)	9e		
10		onexperience-rated contracts:				100		5040
	_	Total premiums or subscription charges paid to ca				10a		5948
		If the carrier, service, or other organization incurre				10h		
9		retention of the contract or policy, other than repo ecify nature of costs.	nted in Part I, line 2 abov	ve, report amo	ount	10b		
Pa	rt l'	IV Provision of Information						
<u>11</u>	Did	d the insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information	on not provided.					

### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110 1210 - 0089

v. 160205

2016

This Form is Open to Public Inspection

Part I Annual Report Identification Information					
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016					
A This return/report is for:	olan a		ers checking this box must attach a list of		
			nation in accordance with the form instr.)		
a single-employer		DFE (specify)	ž.		
B This return/report is: the first return/rep	port   th	ne final return/report			
an amended retu	rn/report	short plan year return/repo	ort (less than 12 months)		
C If the plan is a collectively bargained plan, check he	re				
	Check box if filing under: Form 5558 automatic extension the DFVC program				
Part II Basic Plan Information enter all	(enter description)				
1a Name of plan	requested anormation		dh. Thurs allah		
GROUP LIFE, AD&D AND DISABIL	ITY PLANS F	OR THE	1b Three-digit plan number (PN) ▶ 503		
EMPLOYEES OF PEDIATRIC HOME	SERVICE	× 11 -11-0	1c Effective date of plan		
			01/01/1996		
2a Plan sponsor's name (employer, if for a single-employer p	olan)	<del></del>	2b Employer Identification Number (EIN)		
Mailing address (include room, apt., suite no. and street, of	or P.O. Box)		41-1656511		
City or town, state or province, country, and ZIP or foreign			2c Plan Sponsor's telephone number		
PEDIATRIC HOME RESPIRATORY S	ERVICES INC	•	651-604-5183		
PEDIATRIC HOME SERVICE			2d Business code (see instructions)		
2800 CLEVELAND AVENUE NORTH			621610		
2000 CHEVEHAND AVENUE NORTH					
ROSEVILLE MN	55113				
	33113				
Caution: A penalty for the late or incomplete filing of	this return/report will	be assessed unless reas	onable cause is established.		
Under penalties of perjury and other penalties set forth in the instructions, I	declare that I have examined	this return/report, including accomp			
as the electronic version of this return/report, and to the best of my knowled	dge and belief, it is true, correc	ct, and complete.			
SIGN - O, AA	71717	Dennie &	2 -11		
HERE JEMM (SCO)			\$100 \$100 \$100 \$100 \$100 \$100 \$100 \$100		
Signature of plan administrator	Date	Enter name of individual	signing as plan administrator		
SIGN					
HERE Signature of employer/plan sponsor	Date	Enter name of individual			
Orginatare of employer/plan sponsor	Date	Enter name of individual	signing as employer or plan sponsor		
SIGN					
HERESignature of DFE	Date	Enter name of individual	signing as DFE		
Preparer's name (including firm name, if applicable) and	address (include roon		Preparer's telephone number		
For Paperwork Reduction Act Notice, see the Instruc	tions for Form 5500		Form 5500 (2016)		