Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2016

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

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

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

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [X] special extension (enter description) HURRICANE IRMA

Part II Basic Plan Information—enter all requested information

1a Name of plan
GRANT MEDICAL TRANSPORTATION, INC. 401(K) PROFIT SHARING PLAN & TRUST

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 07/01/1992

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
GRANT MEDICAL TRANSPORTATION, INC.

P.O. BOX 494317
PORT CHARLOTTE, FL 33949-4317

2b Employer Identification Number (EIN) 58-1782427

2c Plan Sponsor's telephone number 941-743-3665

2d Business code (see instructions) 485990

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/02/2017	MICHAEL J. GRANT
	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 signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

Preparer's name (including firm name, if applicable) and address (include room or suite number)

Preparer's telephone number

3a	Plan administrator's name and address [X] Same as Plan Sponsor	**3b**	Administrator's EIN
		3c	Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	**4b**	EIN
a	Sponsor's name	**4c**	PN

5	Total number of participants at the beginning of the plan year	**5**	141
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)**	120
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	156
b	Retired or separated participants receiving benefits	**6b**	5
c	Other retired or separated participants entitled to future benefits	**6c**	23
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	184
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f	Total. Add lines **6d** and **6e**.	**6f**	184
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	109
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	12
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2A 2E 2G 2J 3H

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

9a Plan funding arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[X]	Trust
(4)	[ ]	General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[X]	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)	[X]	**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 Information) - signed by the plan actuary

b General Schedules

(1)	[X]		**H** (Financial Information)
(2)	[ ]		**I** (Financial Information – Small Plan)
(3)	[X]	1	**A** (Insurance Information)
(4)	[X]		**C** (Service Provider Information)
(5)	[X]		**D** (DFE/Participating Plan Information)
(6)	[ ]		**G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

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 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
GRANT MEDICAL TRANSPORTATION, INC. 401(K) PROFIT SHARING PLAN & TRUST

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
GRANT MEDICAL TRANSPORTATION, INC.

D Employer Identification Number (EIN)
58-1782427

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

1 Coverage Information:

(a) Name of insurance carrier
HARTFORD LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0974148	88072	GA-813991	109	01/01/2016	12/31/2016

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
2637	172

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
WELLS FARGO ADVISORS INS AGENCY LLC
3201 N. 4TH AVE, #3
SIOUX FALLS, SD 57104-0700

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2637			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
PROGRESSIVE PENSION ADMIN., INC.
4560 VIA ROYALE, SUITE 4A
FORT MYERS, FL 33919

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	172	TPA COMPENSATION	5

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	845164
5	Current value of plan's interest under this contract in separate accounts at year end	5	700014

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b	Balance at the end of the previous year			7b	729022
c	Additions: (1) Contributions deposited during the year	7c(1)	139337		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	21877		
	(4) Transferred from separate account	7c(4)	0		
	(5) Other (specify below)	7c(5)	71910		
	▶ LOAN PAYMENTS				
	(6) Total additions			7c(6)	233124
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	962146
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	20579		
	(2) Administration charge made by carrier	7e(2)	406		
	(3) Transferred to separate account	7e(3)	29584		
	(4) Other (specify below)	7e(4)	66413		
	▶ LOAN WITHDRAWAL				
	(5) Total deductions			7e(5)	116982
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	845164

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2016** **This Form is Open to Public Inspection.**

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan	**B** Three-digit plan number (PN) ▶	
GRANT MEDICAL TRANSPORTATION, INC. 401(K) PROFIT SHARING PLAN & TRUST		001
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
GRANT MEDICAL TRANSPORTATION, INC.	58-1782427	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions). . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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

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

MASSMUTUAL

04-1590850

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 23 37 38 50 54 55 59 60 62 63 64 65 66 99	NONE	570	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

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

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2016

This Form is Open to Public Inspection.

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
GRANT MEDICAL TRANSPORTATION, INC. 401(K) PROFIT SHARING PLAN & TRUST

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
GRANT MEDICAL TRANSPORTATION, INC.

D Employer Identification Number (EIN)
58-1782427

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT 401

b Name of sponsor of entity listed in (a): HARTFORD LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
06-0974148-000	P	700014

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

a Plan name

b Name of plan sponsor	**c** EIN-PN

SCHEDULE H (Form 5500)

Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
GRANT MEDICAL TRANSPORTATION, INC. 401(K) PROFIT SHARING PLAN & TRUST

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
GRANT MEDICAL TRANSPORTATION, INC.

D Employer Identification Number (EIN)
58-1782427

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	126460	128001
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	200	
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	103500	100709
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)	571724	700014
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	729022	845164
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	**1d(1)**		
	(2) Employer real property	**1d(2)**		
e	Buildings and other property used in plan operation	**1e**		
f	Total assets (add all amounts in lines 1a through 1e)	**1f**	1530906	1773888
	Liabilities			
g	Benefit claims payable	**1g**		
h	Operating payables	**1h**		
i	Acquisition indebtedness	**1i**		
j	Other liabilities	**1j**		
k	Total liabilities (add all amounts in lines 1g through1j)	**1k**	0	0
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	**1l**	1530906	1773888

Part II Income and Expense Statement

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

	Income		(a) Amount	(b) Total
a	**Contributions:**			
	(1) Received or receivable in cash from: **(A)** Employers	**2a(1)(A)**	128001	
	(B) Participants	**2a(1)(B)**	72723	
	(C) Others (including rollovers)	**2a(1)(C)**	1118	
	(2) Noncash contributions	**2a(2)**		
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	**2a(3)**		201842
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	**2b(1)(A)**	21877	
	(B) U.S. Government securities	**2b(1)(B)**		
	(C) Corporate debt instruments	**2b(1)(C)**		
	(D) Loans (other than to participants)	**2b(1)(D)**		
	(E) Participant loans	**2b(1)(E)**	3613	
	(F) Other	**2b(1)(F)**		
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	**2b(1)(G)**		25490
	(2) Dividends: **(A)** Preferred stock	**2b(2)(A)**		
	(B) Common stock	**2b(2)(B)**		
	(C) Registered investment company shares (e.g. mutual funds)	**2b(2)(C)**		
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	**2b(2)(D)**		0
	(3) Rents	**2b(3)**		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	**2b(4)(A)**		
	(B) Aggregate carrying amount (see instructions)	**2b(4)(B)**		
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	**2b(4)(C)**		0
	(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	**2b(5)(A)**		
	(B) Other	**2b(5)(B)**		
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	**2b(5)(C)**		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		39547
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		90
d Total income. Add all **income** amounts in column (b) and enter total	2d		266969
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	23417	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		23417
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	570	
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		570
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		23987
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		242982
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☐ Unqualified **(2)** ☐ Qualified **(3)** ☒ Disclaimer **(4)** ☐ Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? ☒ Yes ☐ No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: TUSCAN & COMPANY, P.A. **(2)** EIN: 26-0254161

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	

			Yes	No	Amount
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		150000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			
o	Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	4o			

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

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? ..... ☐ Yes ☐ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year_____. (See instructions.)

Part V Trust Information

6a Name of trust	**6b** Trust's EIN

6c Name of trustee or custodian	**6d** Trustee's or custodian's telephone number

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2016

This Form is Open to Public Inspection.

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
GRANT MEDICAL TRANSPORTATION, INC. 401(K) PROFIT SHARING PLAN & TRUST

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
GRANT MEDICAL TRANSPORTATION, INC.

D Employer Identification Number (EIN)
58-1782427

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1**

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 04-1590850 06-0974148

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

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

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 **a** Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) **6a**

b Enter the amount contributed by the employer to the plan for this plan year **6b**

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c**

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

Part III Amendments

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box. ..... ☐ **Increase** ☐ **Decrease** ☐ **Both** ☐ **No**

Part IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ..... ☐ **Yes** ☐ **No**

11 **a** Does the ESOP hold any preferred stock? ..... ☐ **Yes** ☐ **No**

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... ☐ **Yes** ☐ **No**

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ..... ☐ **Yes** ☐ **No**

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box* ☐ *and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _____ Day _____ Year _____

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

14 Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	**14a**	
b The plan year immediately preceding the current plan year	**14b**	
c The second preceding plan year	**14c**	

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

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	
b The corresponding number for the second preceding plan year	**15b**	

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

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

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

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

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

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

a Enter the percentage of plan assets held as:
Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

Part VII IRS Compliance Questions

20a Is the plan a 401(k) plan? If "No," skip b	☐ Yes ☐ No
20b How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:	☐ Design-based safe harbor ☐ "Prior year" ADP test ☐ "Current year" ADP test ☐ N/A
21a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:	☐ Ratio percentage test ☐ Average benefit test ☐ N/A
21b Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?	☐ Yes ☐ No

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

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

TUSCAN
& Company, PA
Certified Public Accountants & Consultants

Affiliations
Florida Institute of Certified Public Accountants
American Institute of Certified Public Accountants
Private Companies Practice Section
Tax Division

INDEPENDENT AUDITOR'S REPORT

Plan Administrator
Grant Medical Transportation, Inc.
401(k) Profit Sharing Plan & Trust
P.O. Box 494317
Port Charlotte, FL 33949

Report on the Financial Statements

We were engaged to audit the financial statements (modified cash basis) and the supplementary schedules of the Grant Medical Transportation, Inc. 401(k) Profit Sharing Plan & Trust (the "Plan") which comprise the Statements of Net Assets Available for Plan Benefits (modified cash basis) as of December 31, 2016 and 2015, and the related Statements of Changes in Net Assets Available for Plan Benefits (modified cash basis) for the years then ended, as listed in the accompanying table of contents, and related notes to the financial statements.

Management's Responsibility for the Financial Statements

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting described in Note B; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in these circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in NOTE D, which was certified by Massachusetts Mutual Life Insurance Company (MassMutual), the trustee/custodian of the Plan, except for comparing the information with the related information included in these financial statements and the supplementary schedules. We have been informed by the Plan administrator that the trustee/custodian holds the Plan's investment assets and executes investment transactions. The Plan administrator has obtained a certification from the trustee/custodian as of and for the years ended December 31, 2016 and 2015, that the financial information provided to the Plan administrator by the trustee/custodian is complete and accurate (29 CFR 2520.103-5(c)).

Basis of Accounting

As described in NOTE B, these financial statements and the supplementary schedules were prepared on a modified cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America.

Disclaimer of Opinion

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient, appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.

Other Matter

The supplementary schedules are the responsibility of Plan management, are presented for the purpose of additional analysis and are not a required part of the financial statements but are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, it is inappropriate to and we do not express an opinion on the supplementary schedules referred to above.

Report on Form and Content in Compliance With DOL Rules and Regulations

The form and content of the information included in the financial statements and supplementary schedules, other than that derived from the information certified by the Plan Trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

Tuscan & Company, P.A.

TUSCAN & COMPANY, P.A.
Fort Myers, Florida
September 21, 2017

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2016

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ___

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

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

D Check box if filing under:
- ☒ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☒ special extension (enter description) Hurricane IRMA

Part II Basic Plan Information—enter all requested information

1a Name of plan
Grant Medical Transportation, Inc. 401(k) Profit Sharing Plan & Trust

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 07/01/1992

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
Grant Medical Transportation, Inc.

P.O. Box 494317

Port Charlotte FL 33949-4317

2b Employer Identification Number (EIN) 58-1782427

2c Plan Sponsor's telephone number (941) 743-3665

2d Business code (see instructions) 485990

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	x [signature]	10-2-17	Michael J. Grant
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	x [signature]	10-2-17	Michael J. Grant
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

Preparer's name (including firm name, if applicable) and address (include room or suite number)

Preparer's telephone number

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	**4b** EIN	
a Sponsor's name	**4c** PN	
5 Total number of participants at the beginning of the plan year	**5**	141
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)**	120
a(2) Total number of active participants at the end of the plan year	**6a(2)**	156
b Retired or separated participants receiving benefits	**6b**	5
c Other retired or separated participants entitled to future benefits	**6c**	23
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	184
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f Total. Add lines **6d** and **6e**	**6f**	184
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	109
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	12
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

2A 2E 2G 2J 3H

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

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[X] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[X] Trust	**(3)**	[X] 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)** [X] **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 Information) - signed by the plan actuary

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 1 **A** (Insurance Information)
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST

FINANCIAL STATEMENTS, TOGETHER WITH REPORT OF INDEPENDENT AUDITOR

YEAR ENDED
DECEMBER 31, 2016

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All other schedules required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA) have been omitted because there is no information to report.

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& Company, PA
Certified Public Accountants & Consultants

Affiliations
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American Institute of Certified Public Accountants
Private Companies Practice Section
Tax Division

INDEPENDENT AUDITOR'S REPORT

Plan Administrator
Grant Medical Transportation, Inc.
401(k) Profit Sharing Plan & Trust
P.O. Box 494317
Port Charlotte, FL 33949

Report on the Financial Statements

We were engaged to audit the financial statements (modified cash basis) and the supplementary schedules of the Grant Medical Transportation, Inc. 401(k) Profit Sharing Plan & Trust (the "Plan") which comprise the Statements of Net Assets Available for Plan Benefits (modified cash basis) as of December 31, 2016 and 2015, and the related Statements of Changes in Net Assets Available for Plan Benefits (modified cash basis) for the years then ended, as listed in the accompanying table of contents, and related notes to the financial statements.

Management's Responsibility for the Financial Statements

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting described in Note B; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in these circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in NOTE D, which was certified by Massachusetts Mutual Life Insurance Company (MassMutual), the trustee/custodian of the Plan, except for comparing the information with the related information included in these financial statements and the supplementary schedules. We have been informed by the Plan administrator that the trustee/custodian holds the Plan's investment assets and executes investment transactions. The Plan administrator has obtained a certification from the trustee/custodian as of and for the years ended December 31, 2016 and 2015, that the financial information provided to the Plan administrator by the trustee/custodian is complete and accurate (29 CFR 2520.103-5(c)).

Basis of Accounting

As described in NOTE B, these financial statements and the supplementary schedules were prepared on a modified cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America.

Disclaimer of Opinion

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient, appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.

Other Matter

The supplementary schedules are the responsibility of Plan management, are presented for the purpose of additional analysis and are not a required part of the financial statements but are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, it is inappropriate to and we do not express an opinion on the supplementary schedules referred to above.

Report on Form and Content in Compliance With DOL Rules and Regulations

The form and content of the information included in the financial statements and supplementary schedules, other than that derived from the information certified by the Plan Trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

Tuscan & Company, P.A.

TUSCAN & COMPANY, P.A.
Fort Myers, Florida
September 21, 2017

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
STATEMENTS OF NET ASSETS AVAILABLE FOR PLAN BENEFITS (MODIFIED CASH BASIS)
December 31, 2016 and 2015

ASSETS	2016	2015
Cash	$ -	$ 200
TOTAL CASH	-	200
Investments at fair value:		
MassMutual - Contract number GA-813991		
Pooled separate accounts - mutual funds	700,014	571,724
General account	845,164	729,022
TOTAL INVESTMENTS	1,545,178	1,300,746
Profit Sharing contributions, receivable	128,001	126,460
Notes receivable from participants	100,709	103,500
TOTAL RECEIVABLES	228,710	229,960
NET ASSETS AT FAIR VALUE	1,773,888	1,530,906
NET ASSETS AVAILABLE FOR PLAN BENEFITS	$ 1,773,888	$ 1,530,906

The accompanying notes are an integral part of this statement.

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR PLAN BENEFITS (MODIFIED CASH BASIS)
Year ended December 31, 2016

ADDITIONS TO NET ASSETS ATTRIBUTED TO:	2016
Investment income (loss)	
Interest and dividends - investments	$ 21,877
Interest on notes receivable	3,613
Net appreciation (depreciation) in fair value of investments including net realized gain (loss) on investments	39,547
TOTAL INVESTMENT INCOME (LOSS)	65,037
Contributions (Cash)	
Employee (deferrals and rollovers)	73,841
Employer - match	128,001
Other	90
	201,932
TOTAL ADDITIONS (REDUCTIONS) TO NET ASSETS	266,969
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:	
Benefits paid to participants	23,417
Administrative expenses	570
TOTAL DEDUCTIONS FROM NET ASSETS	23,987
Net increase (decrease) in net assets	242,982
Net assets available for plan benefits:	
BEGINNING OF YEAR	1,530,906
END OF YEAR	$ 1,773,888

The accompanying notes are an integral part of this statement.

NOTE A - DESCRIPTION OF PLAN

The following description of Grant Medical Transportation, Inc. (the "Company") 401(k) (sponsor) Profit Sharing Plan & Trust (the "Plan") Plan number 001 provides only general information. Participants should refer to the Summary Plan Description or Plan agreement for a more complete description of the Plan's provisions.

General

The Plan is a self directed 401(k) defined contribution retirement plan covering substantially all eligible employees of the Company. The Plan includes eligible employees of Grant Medical Transport, Inc. and Ambulance Management Services, LLC. collectively referred to as the Company herein. The Plan was adopted on July 1, 1997 and was amended and restated on January 1, 2016.

The Plan is intended to provide participants with future retirement benefit opportunities. The Plan is subject to the provisions of IRS Code Section 401(k), which allows for employee contributions. The Plan is also subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

No Statement of Changes in Plan Net Assets for the year ended December 31, 2015 has been presented due to the year ended December 31, 2016 was the first year the Plan was required to be audited.

Plan administration

For the years ended December 31, 2016 and 2015, the trustee/custodian of the Plan was Massachusetts Mutual Life Insurance Company (MassMutual). Employer and participant contributions are held and managed by the trustee/custodian, which invests cash received, interest, and dividend income in accordance with participant direction, and makes distributions to participants.

Certain administrative functions are performed by a third party administrator.

NOTE A - DESCRIPTION OF PLAN, CONTINUED

Contributions

An eligible participant's annual salary reduction (deductible) contributions may not exceed the lesser of 100 percent of the participant's compensation or $18,000 for calendar years 2016 and 2015, respectively. Eligible compensation included all employee compensation. Certain participants may contribute up to $6,000 more by taking advantage of "catch up" provisions now authorized by federal law. The Plan allows for "catch up" contributions under certain circumstances.

The Plan allows for discretionary matching contributions funded by the employer as well as discretionary profit sharing contributions. The participant does not have to make 401(k) contributions to be eligible for employer discretionary contributions.

The Plan does not accept rollover contributions.

Forfeitures

Forfeitures resulting from termination of Plan participation of non-vested employees are used to pay plan expenses. Any forfeitures remaining after paying Plan expenses are used to offset Employer contributions. For the year ended December 31, 2016, approximately $4,623 had been used to pay administrative costs of the plan and/or reduce employer contributions.

Participant accounts

Each participant's account is credited with the participant's contributions and the allocation of the Company's contribution and the participant's pro rata share of the Plan earnings as determined and allocated under the Plan as well as the allocated Plan expenses. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account. At December 31, 2016, such accounts allocated to participants who have withdrawn from the Plan but were not paid were $52,109.

Participants may select from an array of investment options to invest in their respective participant account. See Note D for a listing of investment options.

NOTE A - DESCRIPTION OF PLAN, CONTINUED

Vesting

Vesting in employer contributions and related investment earnings occurs upon attainment of normal retirement age (age 59 1/2) or five (5) years of service, but in no event later than the latter of attainment of age 65 or the 5th anniversary of participation, the participant is 100% vested. The Plan allows for early retirement upon attainment of age 55 and six (6) years of service. If employment terminates prior to attainment of retirement age due to death or disability, the participant is 100% vested. However, upon termination of employment for any other reason, a participant is entitled to a portion of their account (excluding salary deferred amounts and any related income earned thereon which is immediately 100% vested) in accordance with the following six year vesting schedule:

Years of Service*	Employer Match	Employer Discretionary
Less than one year	0%	0%
One (1)	0%	0%
Two (2)	20%	20%
Three (3)	40%	40%
Four (4)	60%	60%
Five (5)	80%	80%
Six (6) or more	100%	100%

*Vesting in the employer match and discretionary employer contributions of the participant accounts is based on participant's years of continuous service. The employee is immediately vested in the employee's respective contributions.

The Plan also provides for early vesting due to disability, if determined disabled by a qualified physician.

Payment of benefits

Payments are made upon termination of service, retirement, death, disability, or financial hardship. The participant must receive payment in a lump-sum. Partial withdrawals or installments are only permitted for participants or beneficiaries who must receive required minimum distributions. Based upon certain criteria, in-service distributions are permitted upon the participant's attainment of age 59 1/2 and being fully vested in the Plan.

NOTE A - DESCRIPTION OF PLAN, CONTINUED

Payment of benefits, continued

Upon death of a participant, the vested balance of the participant's account is distributed to the participant's beneficiary in an elected form in a lump sum cash payment Benefits due to terminated employees, either through retirement or otherwise are recorded when paid.

Loans

Loans are available to participants under the Plan. The minimum loan amount is $1,000. Participants are allowed only two loans to be outstanding at any point in time. Loans are secured by the vested balances in the participant's Plan account and bear interest at one percent (1%) over prime.

Interest earned on the loans by the Plan is separately recognized when collected.

Loans become due and payable in full upon termination of employment.

Expenses

Administrative expenses incurred by the Trustee/Custodian, the Servicing Agent and/or Investment Advisors are paid for by the Company or by the Plan with Plan assets. Such expenses include but are not limited to, expenses required by ERISA, required bonding, recordkeeping, and fees and expenses of the Trustee/Custodian.

Plan eligibility

Employees qualify for participation in the elective deferral portion of the Plan upon completion of three months of continuous service and attainment of age 21. The Plan offers semi-annual entry dates on the first day of the first and seventh month of the year following the date the eligibility criteria was met. Thereafter, eligibility for employer contribution allocation a participant must complete 1,000 hours of service per year.

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The following is a summary of the significant accounting policies used in the preparation of these financial statements:

Basis of accounting

The Plan prepares its financial statements using the modified cash basis of accounting. Under this comprehensive basis of accounting, no provision has been made to record items which have been incurred but not paid or earned but not received. This includes items such as interest receivable except for notes receivable which are accrued. Accordingly, the accompanying financial statements are not intended to present financial position or results of operations in conformity with accounting principles generally accepted in the United States of America.

Fair market value is the amount plan sponsors would receive currently if they were to withdraw or transfer funds within the plan prior to their maturity. This fair market value represents contract value adjusted to reflect current market interest rates only to the extent such market rates exceed credit rates.

The Statements of Net Assets Available for Plan Benefits present the fair value of the investment contracts. The Statement of Changes in Net Assets Available for Plan Benefits is prepared on a fair value basis.

Investments

The Plan's investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's investments are carried at fair value based on the fair value of the underlying securities in which the account is invested. The values of the forfeiture accounts are equal to actual cash value and or outstanding balance at the respective year-end. Participant loans are valued at their outstanding unpaid balances, which approximates fair value. Income on loans is only recorded when received, consistent with the modified cash basis of accounting.

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, CONTINUED

Income recognition

Transactions are accounted for using the transaction date. Realized gains or losses are determined on the basis of actual cost. Realized gains and losses are not separately reported as such information is not available. In accordance with the policy of stating investments at fair market value, any change in unrealized appreciation or depreciation for the year is recorded and combined with realized gains and losses on investments in the Statement of Changes in Net Assets Available for Plan Benefits. As such, both realized and unrealized gain/ appreciation and loss/depreciation are recorded net and reflected as investment income (loss).

Interest and dividends are combined and separately reported.

Notes receivable from participants

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income on notes receivable is recorded on the accrual basis. Related fees are recorded as administrative expenses and are expensed when they are incurred. No allowance for credit losses had been recorded as of December 31, 2016 or 2015.

Income tax status

The Plan adopted a Prototype Non-Standardized 401(k) Profit Sharing Plan with a cash or deferral arrangement which received a favorable opinion letter from the Internal Revenue Service (IRS) which stated that the Plan and the related trust are designed in accordance with applicable sections of the Internal Revenue Code. The Plan has been amended since receiving the determination letter. However, the Plan's counsel and Plan administrator believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income taxes has been included in the Plan's financial statements.

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, CONTINUED

Income tax status, continued

Accounting principles generally accepted in the United States of America require the Plan administrator to evaluate tax positions taken by the Plan and recognize a tax liability for any uncertain position that more likely than not would not be sustained upon examination by the IRS, The Plan is subject to routine audits by tax authorities; however, there are currently no audits for any tax periods in progress.

The Plan's annual return Form 5500 for the prior three (3) fiscal years remain open for examination.

Parties-in-interest transactions

Certain Plan investments are managed by Massachusetts Mutual Life Insurance Co., which is the trustee/custodian as defined by the Plan and is considered a party-in-interest. A third party administrator also performs certain Plan administrative functions. Certain administrative functions are performed by officers and employees of the Company (a party-in-interest). No such officer or employee of the Company receives compensation from the Plan.

Plan termination

Although the Company has not expressed any intent to do so, the Plan may be terminated at any time subject to the provisions of ERISA. Upon termination, all assets are to be distributed to vested Plan participants or their beneficiaries. In the event of such termination, participants would become 100% vested in their individual accounts.

Use of estimates

The preparation of financial statements in accordance with modified cash basis of accounting requires the Plan administrator to make estimates and assumptions that affect the reported amounts of assets, liabilities and disclosure of contingent assets and liabilities at the date of the Statements of Net Assets Available for Plan Benefits and the changes in Plan net assets during the reporting period. Accordingly, actual results could differ from these estimates.

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, CONTINUED

Fair value of financial instruments

FASB ASC 825-10-50-21 (formerly Financial Accounting Standards Board Statement No. 107), "Disclosures About Fair Value of Financial Instruments," requires disclosure of fair value information about financial instruments for which it is practicable to estimate that value. The carrying amounts of cash and money market accounts approximate fair value due to the short maturity of those instruments.

Subsequent events

Subsequent events have been evaluated through September 21, 2017, which is the date the financial statements were available to be issued.

NOTE C - MARKET RISK

The Plan investments included pooled separate accounts (mutual funds), which invest in various investment securities and in various companies within various markets. All of the Plan's investments are recorded at fair value in accordance with the reporting requirements governing the Plan. Net changes in asset value is reflected as net appreciation (depreciation) in fair value of investments which includes realized income or loss as well. All such investments are subject to various market and economic risk factors as well as the national and global economies and it is at least reasonably possible that changes in the values (loss of principal) of investment securities will occur in the near term and that such changes could materially affect the participant's account balances and amounts reported in the Plan's financial statements and supplementary schedules.

NOTE D - INVESTMENTS

The following table represents the fair value of the Plan's investments maintained by the Trustee/Custodian at December 31:

		2016		2015	
Trustee/Custodian					
MassMutual	General Account	$ 845,164	*	$ 729,022	*
Pooled Separate Accounts:					
MassMutual	The Hartford Cap Appreciation	36,471		32,068	
MassMutual	PIMCO Total Return	45,071		34,019	
MassMutual	Franklin Conservative Allocation	6,102		5,901	
MassMutual	Franklin Growth Allocation	15,497		15,583	
MassMutual	Franklin Moderate Allocation	254,251	*	241,888	*
MassMutual	Blackrock Lifepath Dynamic 2020	-		-	
MassMutual	Blackrock Lifepath Dynamic 2030	-		-	
MassMutual	Blackrock Lifepath Dynamic 2040	478		-	
MassMutual	Invesco Real Estate	27,558		26,271	
MassMutual	Allianzgi NFJ Small Cap Value	22,151		24,377	
MassMutual	Amcent Vista	-		-	
MassMutual	Franklin Mutual Global Discovery	5,359		2,677	
MassMutual	Pioneer	9,034		5,991	
MassMutual	Pioneer Strategic Inc	25,402		21,436	
MassMutual	Blckrck GL Alloctn	13,865		11,335	
MassMutual	Thornburg Intl Value	88,555		82,427	*
MassMutual	Pioneer M-Cap Value	15,997		14,261	
MassMutual	The Hartford Inflation Plus	-		-	
MassMutual	Pioneer Emerg Mkts	17,491		9,811	
MassMutual	MFS Govt Securities	-		-	
MassMutual	Amcent Equity Income	76,652		9,875	
MassMutual	Janus Forty	28,793		25,126	
MassMutual	Victory Sycamore SM	7,976		5,890	
MassMutual	Unallocated General Account	-		-	
MassMutual	American Century Heritage	3,311		2,788	
	Total Pooled Separate	700,014		571,724	
	Total Investments	$ 1,545,178		$ 1,300,746	

* Investments equal to or greater than 5% of net assets available for Plan benefits at end of plan year.

NOTE D - INVESTMENTS, CONTINUED

Information certified by Trustee

The Plan administrator has elected a method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, Massachusetts Mutual Life Insurance Company ("MassMututal"), the custodian/trustee of the Plan, has certified to the completeness and accuracy of all investments reflected on the accompanying statements of net assets available for Plan benefits as of December 31, 2016 and 2015, and the schedule of assets (held at end of year), and the related investment activity reflected in the Statement of Changes in Net Assets Available for Plan Benefits for the year ended December 31, 2016.

NOTE E - FAIR VALUE MEASUREMENTS

Fair value measurements

FASB ASC 820-10-50-1 (formerly Financial Accounting Standards Board Statement No. 157), "Fair Value Measurements," establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The Plan's investments are reported at fair value in the accompanying Statements of Net Assets Available for Plan Benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to measure fair value of certain financial instruments could result in a different fair value at the reporting date.

The fair value measurement accounting literature establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy consists of three broad levels: Level (1) inputs consist of unadjusted quoted prices in active markets for identical assets and have the highest priority. Level (2) inputs consist of observable inputs other than quoted prices in active markets for identical assets. Level (3) inputs consist of unobservable inputs and have the lowest priority. The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level (1) inputs because they generally provide the most reliable evidence of fair value. Level (3) inputs were only used when Level (1) or Level (2) inputs were not available.

NOTE E - FAIR VALUE MEASUREMENTS, CONTINUED

Level (1) fair value measurements

The fair value of the money market account and mutual funds is based on quoted net asset values of the shares held by the Plan at year-end.

Gains and losses (realized and unrealized) included in changes of net assets available for benefits for the year ended December 31, 2016 are reported as net realized and unrealized gains and losses of fair value of investments.

The Plan's assets are reported at fair value in the accompanying Statements of Net Assets Available for Plan Benefits and consist of the following at December 31:

		Fair Value Measurements Using:		
	Fair Value	Quoted Prices in Active Markets for Identical Assets Level (2)	Significant Unobservable Inputs Level (3)
December 31, 2016			
Pooled Separate Accounts	$ 700,014	$ 700,014	$ -
General Account	845,164	845,164	-
Notes Receivable	100,709	-	100,709
TOTAL	$ 1,645,887	$ 1,545,178	$ 100,709
December 31, 2015			
Pooled Separate Accounts	$ 571,724	$ 571,724	$ -
General Account	729,022	729,022	-
Notes Receivable	103,500	-	103,500
TOTAL	$ 1,404,246	$ 1,300,746	$ 103,500

NOTE E - FAIR VALUE MEASUREMENTS, CONTINUED

Notes receivable from participants consisted of the following at December 31:

	2016	2015*
Beginning Balance	$ 103,500	$ -
New Loans Issued	76,276	-
Loan Payments	(79,843)	-
Loan Interest	3,613	-
Deemed Distribution	(2,837)	-
Transfers	-	-
Ending Balance	$ 100,709	$ -

* Information not available

NOTE F - NOTES RECEIVABLE FROM PARTICIPANTS

Notes receivable consist of loans to Plan participants of $100,709 and $103,500, as of December 31, 2016 and 2015, respectively. At December 31, 2016, the notes carried interest rates ranging from 3.25% to 4.25%. These notes receivables are managed and in the custody of the trustee/custodian. Interest earned on notes receivable is recognized as a separate item when received by the Plan.

NOTE G - RECONCILIATION BETWEEN FINANCIAL STATEMENTS AND FORM 5500

The following is a reconciliation of net assets available for Plan benefits per the financial statements to the Form 5500 at December 31:

	2016	2015	
Net Assets, beginning of period, per the financial statements	$ 1,530,906	$ 1,440,862	*
Net assets, beginning of period, per Form 5500	$ 1,530,906	$ 1,440,862	*
Net Assets, end of year, per the financial statements	$ 1,773,888	$ 1,530,906	
Net assets, end of year, per Form 5500	$ 1,773,888	$ 1,530,906	
Net increase (decrease) per the financial statements	$ 242,982	$ 90,044	*
Net increase (decrease) per Form 5500	$ 242,982	$ 90,044	*

* Unaudited balances

SUPPLEMENTARY SCHEDULES

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
EIN: 58-1782427
PLAN NUMBER: 001
SCHEDULE 1
FORM 5500, PART IV(4)(j) - SCHEDULE H - REPORTABLE TRANSACTIONS*
For the year ended December 31, 2016

IDENTITY OF PARTY INVOLVED	DESCRIPTION OF ASSETS	NUMBER OF PURCHASES	NUMBER OF SALES	TOTAL DOLLAR VALUE OF PURCHASES	TOTAL DOLLAR VALUE OF SALES	DATE

No Reportable Transactions

*Defined as 5% of the current fair value (beginning of the Plan year) of Plan assets.

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
EIN: 58-1782427
PLAN NUMBER: 001
SCHEDULE 2
FORM 5500, PART IV(4)(j) - SCHEDULE H - REPORTABLE TRANSACTIONS*
For the year ended December 31, 2015

IDENTITY OF PARTY INVOLVED	DESCRIPTION OF ASSETS	NUMBER OF PURCHASES	NUMBER OF SALES	TOTAL DOLLAR VALUE OF PURCHASES	TOTAL DOLLAR VALUE OF SALES	DATE

No Reportable Transactions

*Defined as 5% of the current fair value (beginning of the Plan year) of Plan assets.

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
EIN: 58-1782427
PLAN NUMBER: 001
SCHEDULE 3
FORM 5500, PART IV(4)(i) - SCHEDULE H - ASSETS HELD FOR INVESTMENT PURPOSES AT THE END OF PLAN YEAR - (MODIFIED CASH BASIS)
December 31, 2016

IDENTITY OF ISSUER	DESCRIPTION OF INVESTMENT	COST	FAIR VALUE (2)	
MassMutual	General Account	N/A	$ 845,164	*
Pooled Separte Accounts:				
MassMutual	The Hartford Cap Appreciation	N/A	36,471	
MassMutual	PIMCO Total Return	N/A	45,071	
MassMutual	Franklin Conservative Allocation	N/A	6,102	
MassMutual	Franklin Growth Allocation	N/A	15,497	
MassMutual	Franklin Moderate Allocation	N/A	254,251	*
MassMutual	Blackrock Lifepath Dynamic 2020	N/A	-	
MassMutual	Blackrock Lifepath Dynamic 2030	N/A	-	
MassMutual	Blackrock Lifepath Dynamic 2040	N/A	478	
MassMutual	Invesco Real Estate	N/A	27,558	
MassMutual	Allianzgi NFJ Small Cap Value	N/A	22,151	
MassMutual	Amcent Vista	N/A	-	
MassMutual	Franklin Mutual Global Discovery	N/A	5,359	
MassMutual	Pioneer	N/A	9,034	
MassMutual	Pioneer Strategic Inc	N/A	25,402	
MassMutual	Blckrck GL Alloctn	N/A	13,865	
MassMutual	Thornburg Intl Value	N/A	88,555	
MassMutual	Pioneer M-Cap Value	N/A	15,997	
MassMutual	The Hartford Inflation Plus	N/A	-	
MassMutual	Pioneer Emerg Mkts	N/A	17,491	
MassMutual	MFS Govt Securities	N/A	-	
MassMutual	Amcent Equity Income	N/A	76,652	
MassMutual	Janus Forty	N/A	28,793	
MassMutual	Victory Sycamore SM	N/A	7,976	
MassMutual	Unallocated General Account	N/A	-	
MassMutual	American Century Heritage	N/A	3,311	
	Total Pooled Separate Accounts	-	700,014	
Notes Receivable - Participant Loans	Rate of 3.25% - 4.25%	N/A	100,709	
	Total assets held for investment purposes	$ -	$ 1,645,887	

*Investment equal to or greater than 5% of net assets available for Plan benefits (fair value) at the end of the Plan year.

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
EIN: 58-1782427
PLAN NUMBER: 001
SCHEDULE 4
FORM 5500, PART IV(4)(i) - SCHEDULE H - ASSETS HELD FOR INVESTMENT PURPOSES AT THE END OF PLAN YEAR - (MODIFIED CASH BASIS)
December 31, 2015

IDENTITY OF ISSUER	DESCRIPTION OF INVESTMENT	COST	FAIR VALUE (2)	
MassMutual	General Account	N/A	$ 729,022	*
Pooled Separate Accounts:				
MassMutual	The Hartford Cap Appreciation	N/A	32,068	
MassMutual	PIMCO Total Return	N/A	34,019	
MassMutual	Franklin Conservative Allocation	N/A	5,901	
MassMutual	Franklin Growth Allocation	N/A	15,583	
MassMutual	Franklin Moderate Allocation	N/A	241,888	*
MassMutual	Blackrock Lifepath Dynamic 2020	N/A	-	
MassMutual	Blackrock Lifepath Dynamic 2030	N/A	-	
MassMutual	Blackrock Lifepath Dynamic 2040	N/A	-	
MassMutual	Invesco Real Estate	N/A	26,271	
MassMutual	Allianzgi NFJ Small Cap Value	N/A	24,377	
MassMutual	Amcent Vista	N/A	-	
MassMutual	Franklin Mutual Global Discovery	N/A	2,677	
MassMutual	Pioneer	N/A	5,991	
MassMutual	Pioneer Strategic Inc	N/A	21,436	
MassMutual	Blckrck GL Alloctn	N/A	11,335	
MassMutual	Thornburg Intl Value	N/A	82,427	*
MassMutual	Pioneer M-Cap Value	N/A	14,261	
MassMutual	The Hartford Inflation Plus	N/A	-	
MassMutual	Pioneer Emerg Mkts	N/A	9,811	
MassMutual	MFS Govt Securities	N/A	-	
MassMutual	Amcent Equity Income	N/A	9,875	
MassMutual	Janus Forty	N/A	25,126	
MassMutual	Victory Sycamore SM	N/A	5,890	
MassMutual	Unallocated General Account	N/A	-	
MassMutual	American Century Heritage	N/A	2,788	
	Total Pooled Separate Accounts	-	571,724	
Notes Receivable - Participant Loans	Rate of **	N/A	103,500	
	Total assets held for investment purposes	$ -	$ 1,404,246	

*Investment equal to or greater than 5% of net assets available for Plan benefits (fair value) at the end of the Plan year.
** Information not available.

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
EIN: 58-1782427
PLAN NUMBER: 001
SCHEDULE 3
FORM 5500, PART IV(4)(i) - SCHEDULE H - ASSETS HELD FOR INVESTMENT PURPOSES AT THE END OF PLAN YEAR - (MODIFIED CASH BASIS)
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MassMutual	Blackrock Lifepath Dynamic 2020	N/A	-	
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MassMutual	Amcent Equity Income	N/A	76,652	
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MassMutual	Victory Sycamore SM	N/A	7,976	
MassMutual	Unallocated General Account	N/A	-	
MassMutual	American Century Heritage	N/A	3,311	
	Total Pooled Separate Accounts	-	700,014	
Notes Receivable - Participant Loans	Rate of 3.25% - 4.25%	N/A	100,709	
	Total assets held for investment purposes	$ -	$ 1,645,887	

*Investment equal to or greater than 5% of net assets available for Plan benefits (fair value) at the end of the Plan year.

GRANT MEDICAL TRANSPORTATION, INC.
401(k) PROFIT SHARING PLAN & TRUST
EIN: 58-1782427
PLAN NUMBER: 001
SCHEDULE 4
FORM 5500, PART IV(4)(i) - SCHEDULE H - ASSETS HELD FOR INVESTMENT PURPOSES AT THE END OF PLAN YEAR - (MODIFIED CASH BASIS)
December 31, 2015

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MassMutual	Franklin Moderate Allocation	N/A	241,888	*
MassMutual	Blackrock Lifepath Dynamic 2020	N/A	-	
MassMutual	Blackrock Lifepath Dynamic 2030	N/A	-	
MassMutual	Blackrock Lifepath Dynamic 2040	N/A	-	
MassMutual	Invesco Real Estate	N/A	26,271	
MassMutual	Allianzgi NFJ Small Cap Value	N/A	24,377	
MassMutual	Amcent Vista	N/A	-	
MassMutual	Franklin Mutual Global Discovery	N/A	2,677	
MassMutual	Pioneer	N/A	5,991	
MassMutual	Pioneer Strategic Inc	N/A	21,436	
MassMutual	Blckrck GL Alloctn	N/A	11,335	
MassMutual	Thornburg Intl Value	N/A	82,427	*
MassMutual	Pioneer M-Cap Value	N/A	14,261	
MassMutual	The Hartford Inflation Plus	N/A	-	
MassMutual	Pioneer Emerg Mkts	N/A	9,811	
MassMutual	MFS Govt Securities	N/A	-	
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MassMutual	Janus Forty	N/A	25,126	
MassMutual	Victory Sycamore SM	N/A	5,890	
MassMutual	Unallocated General Account	N/A	-	
MassMutual	American Century Heritage	N/A	2,788	
	Total Pooled Separate Accounts	-	571,724	
Notes Receivable - Participant Loans	Rate of **	N/A	103,500	
	Total assets held for investment purposes	$ -	$ 1,404,246	

*Investment equal to or greater than 5% of net assets available for Plan benefits (fair value) at the end of the Plan year.
** Information not available.