

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089
		2011
		This Form is Open to Public Inspection

Part I	Annual Report Identification Information
For calendar plan year 2011 or fiscal plan year beginning <u>03/01/2011</u> and ending <u>02/29/2012</u>	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan; or ☒ a single-employer plan; ☐ a DFE (specify) ____
B This return/report is:	☐ the first return/report; ☐ the final return/report; ☒ an amended return/report; ☐ a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information
1a Name of plan <u>CHRIST HOSPITAL TAX DEFERRED ANNUITY PLAN</u>	1b Three-digit plan number (PN) ▶ <u>004</u> 1c Effective date of plan <u>03/01/1987</u>
2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan) <u>THE CHRIST HOSPITAL</u> <u>2139 AUBURN AVENUE</u> <u>CINCINNATI, OH 45219-2906</u>	2b Employer Identification Number (EIN) <u>31-0538525</u> 2c Sponsor's telephone number <u>513-585-6000</u> 2d Business code (see instructions) <u>622000</u>

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	<u>Filed with authorized/valid electronic signature.</u>	<u>10/15/2012</u>	<u>CHRIS E. BERGMAN</u>
	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

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

Form 5500 (2011)
v.012611

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") THE CHRIST HOSPITAL 2139 AUBURN AVENUE CINCINNATI, OH 45219-2906	3b Administrator's EIN 31-0538525 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	1
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6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).		
a Active participants.....	6a	0
b Retired or separated participants receiving benefits.....	6b	0
c Other retired or separated participants entitled to future benefits.....	6c	1
d Subtotal. Add lines 6a , 6b , and 6c	6d	1
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	0
f Total. Add lines 6d and 6e	6f	1
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	0
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 2L

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

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

a Pension Schedules

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

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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▶ **Complete all entries in accordance with the instructions to the Form 5500.**OMB Nos. 1210-0110
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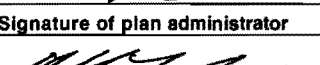
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☐ special extension (enter description) _____

Basic Plan Information - enter all requested information

1 a Name of plan CHRIST HOSPITAL TAX DEFERRED ANNUITY PLAN	1 b Three-digit plan number (PN) ▶ 004
2 a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan) THE CHRIST HOSPITAL 2139 AUBURN AVENUE CINCINNATI OH 45219-2906	1 c Effective date of plan 03/01/1987
	2 b Employer Identification Number (EIN) 31-0538525
	2 c Sponsor's telephone number 513-585-6000
	2 d Business code (see instructions) 622000

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		10-15-12	RICK TOLSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10-15-12	RICK TOLSON
	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

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3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

5 Total number of participants at the beginning of the plan year

5 1

6 Number of participants as of the end of the plan year (welfare plans complete only lines **6a**, **6b**, **6c**, and **6d**):

a Active participants

6a 0

b Retired or separated participants receiving benefits

6b 0

c Other retired or separated participants entitled to future benefits

6c 1

d Subtotal. Add lines **6a**, **6b**, and **6c**

6d 1

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

6e 0

f Total. Add lines **6d** and **6e**

6f 1

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

6g 0

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

6h 0

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)

7

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9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
 (2) ☐ Code section 412(e)(3) insurance contracts
 (3) ☐ Trust
 (4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
 (2) ☐ Code section 412(e)(3) insurance contracts
 (3) ☐ Trust
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