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| 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). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | OMB Nos. 1210-0110 1210-0089 2011 This Form is Open to Public Inspection |
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| Part I | Annual Report Identification Information |
| For calendar plan year 2011 or fiscal plan year beginning <u>11/01/2011</u> and ending <u>10/31/2012</u> | |
| A This return/report is for: | <input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____ |
| B This return/report is: | <input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months). |
| C If the plan is a collectively-bargained plan, check here. | <input type="checkbox"/> |
| D Check box if filing under: | <input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description) |

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| Part II | Basic Plan Information —enter all requested information | | | | | | |
| 1a Name of plan <u>ADELINE LAPLANTE MEMORIAL CENTER TAX DEFERRED ANNUITY</u> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>11/01/1985</u></td> </tr> </table> | 1b Three-digit plan number (PN) ▶ | <u>001</u> | 1c Effective date of plan <u>11/01/1985</u> | | | |
| 1b Three-digit plan number (PN) ▶ | <u>001</u> | | | | | | |
| 1c Effective date of plan <u>11/01/1985</u> | | | | | | | |
| 2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan) <u>ADELINE LAPLANTE MEMORIAL CENTER, INC</u> <u>P.O. BOX 56</u> <u>PEACE DALE, RI 02883</u> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">2b Employer Identification Number (EIN) <u>05-0394602</u></td> <td style="width: 20%;"></td> </tr> <tr> <td colspan="2">2c Sponsor's telephone number</td> </tr> <tr> <td colspan="2">2d Business code (see instructions) <u>624310</u></td> </tr> </table> | 2b Employer Identification Number (EIN) <u>05-0394602</u> | | 2c Sponsor's telephone number | | 2d Business code (see instructions) <u>624310</u> | |
| 2b Employer Identification Number (EIN) <u>05-0394602</u> | | | | | | | |
| 2c Sponsor's telephone number | | | | | | | |
| 2d Business code (see instructions) <u>624310</u> | | | | | | | |
| <u>126 WILLIARD AVE</u> <u>WAKEFIELD, RI 02879</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.

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| SIGN HERE | Filed with authorized/valid electronic signature. | <u>04/15/2013</u> | <u>MAUREEN WILLIAMS</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)
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| 3a Plan administrator's name and address (if same as plan sponsor, enter "Same") ADELINE LAPLANTE MEMORIAL CENTER, INC P.O. BOX 56 PEACE DALE, RI 02883 | 3b Administrator's EIN 05-0394602 3c Administrator's telephone number 401-789-3081 |
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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 | 19 |
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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 | 17 |
| b Retired or separated participants receiving benefits..... | 6b | |
| c Other retired or separated participants entitled to future benefits..... | 6c | |
| d Subtotal. Add lines 6a , 6b , and 6c | 6d | 17 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits..... | 6e | |
| f Total. Add lines 6d and 6e | 6f | 17 |
| g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... | 6g | |
| h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6h | |

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| 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:

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| 9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input checked="" type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor | 9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input checked="" type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> 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)