

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 2013 This Form is Open to Public Inspection
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Part I Annual Report Identification Information For calendar plan year 2013 or fiscal plan year beginning <u>11/01/2013</u> and ending <u>03/15/2014</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 checked="" type="checkbox"/> the final return/report;
	<input type="checkbox"/> an amended return/report;	<input checked="" 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)	

Part II Basic Plan Information —enter all requested information		
1a Name of plan <u>ADELINE LAPLANTE MEMORIAL CENTER TAX DEFERRED ANNUITY</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; include room or suite number (employer, if for a single-employer plan) <u>ADELINE LAPLANTE MEMORIAL CENTER, INC</u> <u>P.O. BOX 56</u> <u>PEACE DALE, RI 02883</u>	2b Employer Identification Number (EIN) <u>05-0394602</u>	
	2c Sponsor's telephone number <u>401-294-3990</u>	
	2d Business code (see instructions) <u>624310</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	Filed with authorized/valid electronic signature.	<u>09/11/2014</u>	<u>EDWARD MCDERMOTT</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
Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional)			Preparer's telephone number (optional)

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

Form 5500 (2013)
v. 130118

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address 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
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 17
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
c Other retired or separated participants entitled to future benefits		6c
d Subtotal. Add lines 6a , 6b , and 6c		6d 0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		6e
f Total. Add lines 6d and 6e		6f 0
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
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2L		
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) <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
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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

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 4085 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 2013 This Form is Open to Public Inspection
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Part I Annual Report Identification Information			
For calendar plan year 2013 or fiscal plan year beginning		11/01/2013	and ending
		03/15/2014	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input checked="" type="checkbox"/> a single-employer plan;	<input type="checkbox"/> a multiple-employer plan; or <input type="checkbox"/> a DFE (specify) ____	
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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"/> special extension (enter description)	<input type="checkbox"/> automatic extension;	<input type="checkbox"/> the DFVC program;

Part II Basic Plan Information—enter all requested information			
1a Name of plan	1b Three-digit plan number (PN) ▶		
ADELINE LAPLANTE MEMORIAL CENTER TAX DEFERRED ANNUITY	001		
	1c Effective date of plan		
	11/01/1985		
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)	2b Employer Identification Number (EIN)		
ADELINE LAPLANTE MEMORIAL CENTER, INC	05-0394602		
	2c Sponsor's telephone number		
P.O. BOX 56	401-294-3990		
	2d Business code (see instructions)		
PEACE DALE	RI 02883	WAKEFIELD	RI 02879
	624310		

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		9/11/14	Edward McDermott
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		9/11/14	Edward McDermott
	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. (optional)			Preparer's telephone number (optional)

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address 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	17
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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	
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a, 6b, and 6c	6d	0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	0
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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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2L

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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)