Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form 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).

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

| | ension Benefit Guaranty Corporation | ▶ Complete all entries in accor | rdance wit | h the instructions to the Form 550 | 0-SF. | | | | |
|------|--|---|---------------|---------------------------------------|---------|------------------------------|--------------------------|--|--|
| | | lentification Information | | | | | | | |
| For | calendar plan year 2010 or fisca | al plan year beginning 01/01/201 | 10 | and ending 1 | 2/31/2 | 2010 | | | |
| Α - | This return/report is for: | single-employer plan | multiple-e | employer plan (not multiemployer) | | one-participa | ant plan | | |
| | B This return/report is for: first return/report final return/report | | | | | | | | |
| | | an amended return/report | short plar | year return/report (less than 12 mo | nths) | | | | |
| C | Check box if filing under: | Form 5558 | automatio | extension | | DFVC progr | am | | |
| | | special extension (enter descripti | on) | | | | | | |
| Pa | rt II Basic Plan Inforn | nation—enter all requested inform | nation | | | | | | |
| | Name of plan | | | | 1b | Three-digit | | | |
| | CADE CANCER CENTER RETI | REMENT PLAN | | | | plan number | 001 | | |
| | | | | | | (PN) • | | | |
| | | | | | 1c | Effective date of 01/01/2 | | | |
| | Plan enoneor's name and addre | ess (employer, if for single-employer | r nlan) | | 2h | | ification Number | | |
| | CADE CANCER CENTERS OF | | ι ριατι) | | | (EIN) 91-190 | | | |
| 4000 | ONE 400THAN OUTE 400 | | | | 2c | Plan sponsor's | telephone number | | |
| | 3 N.E. 130TH LN., SUITE 120 LAND, WA 98034 | | | | 24 | | (9-2717 | | |
| | | | | | Zū | 62111 | (see instructions) | | |
| 3a | Plan administrator's name and | address (if same as Plan sponsor, e | enter "Same | e") | 3b | b Administrator's EIN | | | |
| CAS(| CADE CANCER CENTERS OF .C. | WASHINGTON, 12303 N.E. KIRKLAND, | | SUITE 120 | _ | 91-1901133 | | | |
| | | | | | 3C | | telephone number '9-2717 | | |
| 4 1 | the name and/or EIN of the pla | an sponsor has changed since the la | ast return/re | port filed for this plan, enter the | 4b EIN | | | | |
| ı | name, EIN, and the plan numbe | r from the last return/report. Sponse | or's name | | 4c PN | | | | |
| 52 | Total number of participants at | the beginning of the plan year | | | 5a | <u> </u> | | | |
| | 5a Total number of participants at the beginning of the plan yearb Total number of participants at the end of the plan year | | | | | a | | | |
| | · · | ith account balances as of the end c | | | 5b | | 40 | | |
| С | · | | | • | 5c | | 48 | | |
| 6a | Were all of the plan's assets d | luring the plan year invested in eligib | ole assets? | (See instructions.) | | | X Yes No | | |
| b | | | | ndent qualified public accountant (IQ | | | X Vac D Na | | |
| | | | | ons.)SF and must instead use Form 55 | | | ^ Yes No | | |
| Pa | rt III Financial Informa | | ·01111 5500- | SF and must instead use Form 55 | υυ. | | | | |
| 7 | Plan Assets and Liabilities | | | (a) Deminsion of Vers | | (h) F., | L of Voca | | |
| ′ _ | Total plan assets | | 7- | (a) Beginning of Year | 5 | (a) End | 1 of Year 1567366 | | |
| - | . otal pran according | | 7a 7b | | 1001000 | | | | |
| | • | 7b from line 7a) | | 1270655 | 5 | | 1567366 | | |
| 8 | Income, Expenses, and Transf | | 76 | (a) Amount | | (b) Total | | | |
| а | Contributions received or recei | | | (a) Amount | | (6) | Total | | |
| _ | | | 8a(1) | 93423 | 3 | | | | |
| | (2) Participants | | 8a(2) | 178308 | 3 | | | | |
| | (3) Others (including rollovers) |) | 8a(3) | | | | | | |
| b | Other income (loss) | | 8b | 123707 | 07 | | | | |
| С | Total income (add lines 8a(1), | 8a(2), 8a(3), and 8b) | 8c | | 395 | | | | |
| d | . ` ` | rollovers and insurance premiums | 8d | 98727 | 7 | | | | |
| е | Certain deemed and/or correct | ive distributions (see instructions) | 8e | | | | | | |
| f | Administrative service provider | rs (salaries, fees, commissions) | 8f | | | | | | |
| g | Other expenses | | 8g | | | | | | |
| h | Total expenses (add lines 8d, 8 | Be, 8f, and 8g) | 8h | | | | 98727 | | |
| i | Net income (loss) (subtract line | e 8h from line 8c) | 8i | | | | 296711 | | |
| | Transfers to (from) the plan (se | ee instructions) | 8i | | | | | | |

| | F | Form 5500-SF 2010 Page 2- | | | | |
|-----|---------|---|---------|---------|-----------|-------------------|
| Par | t IV | Plan Characteristics | | | | |
| Эа | | plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Char | acteris | stic Co | des in | the instructions: |
| h | | 2E 2G 2J 2T 3D plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Chara | octoric | tic Co | dos in t | ho instructions: |
| | 11 1116 | plan provides wellare benefits, effer the applicable wellare feature codes from the cist of Fian Ghara | acteris | 110 000 | Jes III t | ie iistructions. |
| art | t V | Compliance Questions | | • | | |
| 0 | Duri | ng the plan year: | | Yes | No | Amount |
| а | | there a failure to transmit to the plan any participant contributions within the time period described in CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program) | 10a | | X | |
| b | | e there any nonexempt transactions with any party-in-interest? (Do not include transactions reported ne 10a.) | 10b | | X | |
| С | Was | s the plan covered by a fidelity bond? | 10c | | X | |
| d | Did t | the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud shonesty? | 10d | | X | |
| е | Wer | e any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, rance service or other organization that provides some or all of the benefits under the plan? (See uctions.) | 10e | | X | |
| f | Has | the plan failed to provide any benefit when due under the plan? | 10f | | X | |
| g | Did t | the plan have any participant loans? (If "Yes," enter amount as of year end.) | 10q | | X | |
| h | If thi | s is an individual account plan, was there a blackout period? (See instructions and 29 CFR 0.101-3.) | 10h | | X | |
| i | | h was answered "Yes," check the box if you either provided the required notice or one of the eptions to providing the notice applied under 29 CFR 2520.101-3 | 10i | | | |
| art | VI | Pension Funding Compliance | | | | |
| 11 | Is thi | s a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and con | | | | |
| 2 | | is a defined contribution plan subject to the minimum funding requirements of section 412 of the Code | | | | |
| | (If "Y | es," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.) | | | | |
| а | | vaiver of the minimum funding standard for a prior year is being amortized in this plan year, see instru ting the waiver | | | | |
| lf | you c | ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13. | | _ | - | |
| b | Ente | r the minimum required contribution for this plan year | | | 12b | |
| | | r the amount contributed by the employer to the plan for this plan year | | | 12c | |
| d | | ract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left tive amount) | | | 12d | |
| е | Will t | the minimum funding amount reported on line 12d be met by the funding deadline? | | | | Yes No N/A |
| art | VII | Plan Terminations and Transfers of Assets | | | | |
| 3а | Has | a resolution to terminate the plan been adopted during the plan year or any prior year? | | | | Yes X No |
| | | es," enter the amount of any plan assets that reverted to the employer this year | | | 13a | |
| b | | e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought e PBGC? | | | | Yes X No |
| С | | ring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the assets or liabilities were transferred. (See instructions.) | he pla | n(s) to | | |

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

13c(1) Name of plan(s):

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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.

13c(2) EIN(s)

13c(3) PN(s)

| SIGN | Filed with authorized/valid electronic signature. | 07/13/2011 | CAROL M. VANHAELST | | | | | |
|------|---|------------|--|--|--|--|--|--|
| HERE | 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 | | | | | |

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee **Benefit Plan**

This form 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

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

Internal Revenue Code (the Code).

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

| | art I Annual Report Identification Information | | 2 | | | | | | |
|-------|--|--------------|--|-----------|--|--|--|--|--|
| For | For calendar plan year 2010 or fiscal plan year beginning and ending | | | | | | | | |
| Α | This return/report is for: X single-employer plan | multiple-e | ple-employer plan (not multiemployer) | | | | | | |
| В | This return/report is for: first return/report | final return | n/report | | | | | | |
| | an amended return/report | short plan | year return/report (less than 12 mor | iths) | | | | | |
| C | Check box if filing under: Form 5558 | automatic | extension | 550 | DFVC program | | | | |
| | special extension (enter description | | | | | | | | |
| P | art II Basic Plan Information—enter all requested inform | NAMES . | | | | | | | |
| | Name of plan | ation | | 1h | Three-digit | | | | |
| | CADE CANCER CENTER RETIREMENT PLAN | | | 4.55 | plan number | | | | |
| 3 (2) | | | | | (PN) 001 | | | | |
| | | | | 1c | Effective date of plan 01/01/2005 | | | | |
| | Plan sponsor's name and address (employer, if for single-employer | plan) | | 2b | Employer Identification Number | | | | |
| CAS | CADE CANCER CENTERS OF WASHINGTON, P.L.L.C. | | | | (EIN) 91-1901133 | | | | |
| 1230 | 03 N.E. 130TH LN., SUITE 120 | | | 2C | Plan sponsor's telephone number 206-779-2717 | | | | |
| KIR | (LAND WA 98034 | | | 2d | Business code (see instructions) 621111 | | | | |
| 3a | Plan administrator's name and address (if same as Plan sponsor, e | nter "Same | 3") | 3b | Administrator's EIN | | | | |
| SAN | lE . | | <i>"</i> | | 91-1901133 | | | | |
| | | | | | Administrator's telephone number 206-779-2717 | | | | |
| | f the name and/or EIN of the plan sponsor has changed since the land name, EIN, and the plan number from the last return/report. Sponso | | port filed for this plan, enter the | 4b | EIN | | | | |
| | Tame, 2nd, and the plan hamber from the last return report. Openio | / a name | | 4c | PN | | | | |
| 5a | Total number of participants at the beginning of the plan year | | | 5a | 45 | | | | |
| b | Total number of participants at the end of the plan year | ••••• | | 5b | 48 | | | | |
| C | Total number of participants with account balances as of the end of | 1022 | | | | | | | |
| | complete this item) | | | 5c | 48 | | | | |
| 6a | Were all of the plan's assets during the plan year invested in eligib | le assets? | (See instructions.) | ******* | X Yes No | | | | |
| D | Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility | an indeper | ident qualified public accountant (IQI | PA) | Yes No | | | | |
| | If you answered "No" to either 6a or 6b, the plan cannot use F | orm 5500- | SF and must instead use Form 55 | 00. | | | | | |
| Pa | rt III Financial Information | | | | - | | | | |
| 7 | Plan Assets and Liabilities | | (a) Beginning of Year | | (b) End of Year | | | | |
| a | Total plan assets | . 7a | 1270655 | | 1567366 | | | | |
| b | Total plan liabilities | . 7b | | | | | | | |
| С | Net plan assets (subtract line 7b from line 7a) | . 7c | 1270655 | | 1567366 | | | | |
| 8 | Income, Expenses, and Transfers for this Plan Year | | (a) Amount | (b) Total | | | | | |
| а | Contributions received or receivable from: | | | lie: | | | | | |
| | (1) Employers | | 93423 | - 885 | | | | | |
| | (2) Participants | | 178308 | | | | | | |
| | (3) Others (including rollovers) | | | | | | | | |
| b | Other income (loss) | | 123707 | 100 | [44] | | | | |
| C | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | . 8c | | | 395438 | | | | |
| d | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | . 8d | 98727 | | | | | | |
| е | Certain deemed and/or corrective distributions (see instructions) | . 8e | | | | | | | |
| f | Administrative service providers (salaries, fees, commissions) | . 8f | | | | | | | |
| g | Other expenses | | | | | | | | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | | | 21 | 98727 | | | | |
| i | Net income (loss) (subtract line 8h from line 8c) | | | 1 | 296711 | | | | |
| i | Transfers to (from) the plan (see instructions) | | The state of the s | ide | | | | | |
| 1.00 | | | | | | | | | |

| Form | CCO | ~ ^ _ | DOAD |
|------|-----|-------|------|
| | | | |
| | | | |

Signature of employer/plan sponsor

| 522 | - | 12 |
|-------|---|-----|
| Dann | - | 11 |
| PALIE | | 110 |

Enter name of individual signing as employer or plan sponsor

| | | | DANKE TO SERVICE | | - | | | | |
|--------------|---|---|---|------------|---------|-----------------|---------------|----------------------|-----------------|
| Par | | | | | | | | EC 7 2020101 | 1 37 |
| | If the plan provides pension benefits, enter the applicable pension fe 2A 2E 2G 2J 2T 3D | | | | | | | | |
| b | If the plan provides welfare benefits, enter the applicable welfare fea | ature codes from the | List of Plan Chara | cteris | tic Co | des in 1 | the instructi | ons: | |
| Part | V Compliance Questions | , je min | | | | | | | |
| 10 | During the plan year: | | 100000 | | Yes | No | - | Amount | |
| a | Was there a failure to transmit to the plan any participant contribution 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiducions) | ary Correction Progr | am) | 10a | | х | | | |
| b | Were there any nonexempt transactions with any party-in-interest? on line 10a.) | (Do not include trans | actions reported | 10b | | х | | | |
| C | Was the plan covered by a fidelity bond? | | *************************************** | 10c | | Х | | | 1000000 |
| d | Did the plan have a loss, whether or not reimbursed by the plan's fit or dishonesty? | delity bond, that was | caused by fraud | 10d | | х | | | |
| е | Were any fees or commissions paid to any brokers, agents, or other insurance service or other organization that provides some or all of instructions.) | r persons by an insur | ance carrier, | 10e | | × | | | |
| f | Has the plan failed to provide any benefit when due under the plan? | | | 10f | | Х | | | |
| g | Did the plan have any participant loans? (If "Yes," enter amount as | | | - | - | X | | | |
| h | If this is an individual account plan, was there a blackout period? (S 2520.101-3.) | ee instructions and 2 | 9 CFR | 10g 10h | | x | 1 | | |
| i | If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101-: | required notice or or | ne of the | 10ii | | | | | |
| Part | No. 17 (A) | | | | | <u> </u> | STATE CARPO | | |
| 11 | Is this a defined benefit plan subject to minimum funding requiremen 5500)) | nts? (If "Yes," see ins | tructions and com | plete | Sched | dule SB | (Form | ☐ Ye: | з П Мо |
| 12 | Is this a defined contribution plan subject to the minimum funding re | equirements of section | n 412 of the Code | Or se | ction | 302 of | EDIGAT | ☐ Ye | H |
| lf y | (If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applical If a waiver of the minimum funding standard for a prior year is being granting the waiver | amortized in this pla | Mon d skip to line 13. | th | | enter th Day | e date of th | e letter r Year | uling |
| b | Enter the minimum required contribution for this plan year | | | | | 12b | | | |
| C | Enter the amount contributed by the employer to the plan for this pla | ın year | *************************************** | | L | 12c | | 7 (8.84) | |
| d | Subtract the amount in line 12c from the amount in line 12b. Enter the negative amount) | *************************************** | *************************************** | | | 12d | | | |
| | Will the minimum funding amount reported on line 12d be met by the | funding deadline? | | | | | Yes | No | N/A |
| Part | | | | | | | _ | 78. | |
| 13a | Has a resolution to terminate the plan been adopted during the plan | year or any prior yea | ar? | •••••• | | | | Yes | No |
| | If "Yes," enter the amount of any plan assets that reverted to the em | ployer this year | | | | 13a | | | |
| | Were all the plan assets distributed to participants or beneficiaries, t of the PBGC? | *************************************** | ************* | | | 20022334524 | 17) mag/mag/m | Yes | No |
| | If during this plan year, any assets or liabilities were transferred from which assets or liabilities were transferred. (See instructions.) | n this plan to another | plan(s), identify the | ne plai | n(s) to |) | | | |
| 1 | 3c(1) Name of plan(s): | | | | 13 | c(2) El | N(s) | 13c(| 3) PN(s) |
| | | | | | | | | | |
| | | | | | | | | | |
| Caut | on: A penalty for the late or incomplete filing of this return/repo | rt will be assessed | uniess reasonab | le cau | se is | establ | ished. | - | |
| Unde SB o | penalties of perjury and other penalties set forth in the instructions, Schedule MB completed and signed by an enrolled actuary, as well it is true, correct, and complete. | I declare that I have | evamined this retu | irn/ror | ort in | محاله دراه | _ 12 | ole, a Sc nowledg | nedule e and |
| SIGI | × / All | 1 715111 | CAROL M. VAN | MAEL | ST | - | | | |
| HER | Signature of planadministrator | Date | Enter name of in | ndividu | ıal sig | ning as | plan admir | nistrator | |
| SIGI | | D. | | | | | | | |
| | oj vignature vi employer/plan SDORSOF | Date | Enter name of in | divide | not ata | _: | | 22.42 . 00 | |

Date