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 | | lentification Information | | | | | |
|---|---|---|-----------------------------------|--|-------------------------------|-------------------------------------|--------|
| For cale | ndar plan year 2016 or fisc | al plan year beginning 01/01/2016 | | and ending 12/31/2016 | | | |
| A This | return/report is for: | a multiemployer plan | participating | ployer plan (Filers checking this be employer information in accordance | | | ns.) |
| | | a single-employer plan | a DFE (specif | fy) | | | |
| B This | return/report is: | the first return/report | the final retur | n/report | | | |
| | | an amended return/report | a short plan y | rear return/report (less than 12 mo | onths) | | |
| C If the | plan is a collectively-barga | ained plan, check here | | | | • [| |
| D Chec | k box if filing under: | X Form 5558 | automatic exte | ension | the | e DFVC program | |
| | special extension (enter description) | | | | | | |
| Part II | Basic Plan Inform | nation—enter all requested inform | nation | | | | |
| | ne of plan | oritor air requested rinerin | iadon | | 1b | Three-digit plan | |
| CANCER CARE NW WELFARE BENEFIT PLAN | | | | | number (PN) ▶ | 502 | |
| | | | | | 1c | Effective date of pla 01/01/2008 | an |
| | | er, if for a single-employer plan) | | | 2b | Employer Identifica | tion |
| Mai Citv | ing address (include room, or town, state or province | , apt., suite no. and street, or P.O. B country, and ZIP or foreign postal c | ox) code (if foreign, see inst | ructions) | | Number (EIN) 91-1007627 | |
| - | R CARE NORTHWEST CE | | nodo (ii foroigni, odo iniot | . dollorio, | 2c | Plan Sponsor's tele | enhone |
| | | | | | | number | |
| | | | | | | 509-228-1000 | |
| | VERCLER, STE.101 IE VALLEY, WA 99216 | | I. VERCLER, STE. 101 | 16 | 2d | Business code (see instructions) | Э |
| SPUKAN | IE VALLET, WA 99216 | SPORA | ANE VALLEY, WA 9921 | 10 | | 621111 | |
| | | | | | | | |
| | | | | | | | |
| Caution | : A penalty for the late or | incomplete filing of this return/re | eport will be assessed | unless reasonable cause is es | tabli | shed. | |
| | | er penalties set forth in the instruction ell as the electronic version of this re | | | | | |
| | | | | | | | |
| SIGN | Filed with authorized/valid | l electronic signature. | 10/09/2017 | WARREN BENINCOSA | | | |
| HERE | Signature of plan admi | nistrator | Date | Enter name of individual signing | signing as plan administrator | | |
| | | | | | | | |
| SIGN HERE | | | | | | | |
| HEKE | Signature of employer/ | plan sponsor | Date | Enter name of individual signing | ng as | employer or plan sp | onsor |
| | | | | | | | |
| SIGN | | | | | | | |
| HERE Signature of DFE Date Enter name of individual signing | | | | ng as | DFE | | |
| Prepare | 's name (including firm na | me, if applicable) and address (inclu | de room or suite numb | | rer's | telephone number | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

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| 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, EIN and the plan number from the last return/report: | /report filed for this plan, enter the name, | 4b EIN | _ |
| а | Sponsor's name | | 4c PN | |
| 5 | Total number of participants at the beginning of the plan year | | 5 21 | 9 |
| 6 | Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d). | d (welfare plans complete only lines 6a(1), | | |
| a(1 |) Total number of active participants at the beginning of the plan year | | 6a(1) 219 | 9 |
| a(2 | Total number of active participants at the end of the plan year | | 6a(2) 214 | 4 |
| b | Retired or separated participants receiving benefits | | 6b | _ |
| С | Other retired or separated participants entitled to future benefits | | 6c | _ |
| d | Subtotal. Add lines 6a(2), 6b, and 6c. | | 6d 214 | 4 |
| е | Deceased participants whose beneficiaries are receiving or are entitled to rec | ceive benefits. | 6e | _ |
| f | Total. Add lines 6d and 6e . | | 6f | _ |
| g | Number of participants with account balances as of the end of the plan year (complete this item) | | 6g | |
| h | Number of participants that terminated employment during the plan year with less than 100% vested | | 6h | |
| 7 | Enter the total number of employers obligated to contribute to the plan (only r | multiemployer plans complete this item) | 7 | |
| b | If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature code. 4A 4B 4D 4E 4F 4H | les from the List of Plan Characteristics Codes | s in the instructions: | |
| 9a | Plan funding arrangement (check all that apply) | 9b Plan benefit arrangement (check all that | at apply) | |
| | (1) X Insurance (2) Code section 412(e)(3) insurance contracts | (1) X Insurance (2) Code section 412(e)(3) | insurance contracts | |
| | (3) Trust | (3) Trust | modranice contracts | |
| | (4) X General assets of the sponsor | (4) X General assets of the sp | ponsor | |
| 10 | Check all applicable boxes in 10a and 10b to indicate which schedules are at | · · · · | · | _ |
| • | Pension Schedules | b General Schedules | | |
| а | (1) R (Retirement Plan Information) | (1) H (Financial Inform | mation) | |
| | (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | (2) I (Financial Inform (3) X 3 A (Insurance Inform (4) C (Service Provide | , | |
| | (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | (5) D (DFE/Participati (6) G (Financial Trans | ing Plan Information) saction Schedules) | |
| | | | | |

| Part III | Form M-1 Compliance Information (to be completed by welfare benefit plans) |
|------------------------|--|
| 11a If the 2520 | plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 1.101-2.) |
| lf "Y€ | es" is checked, complete lines 11b and 11c. |
| 11b Is the | e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) |
| Rece | r 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 eipt 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 eipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) |
| Rece | eipt Confirmation Code |

Form 5500 (2016)

Page 3

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

OMB No. 1210-0110

2016

| | | pursuant to EF | RISA section 103(a)(2). | IIIIs FC | Inspection | |
|--|---|---------------------------------------|--|---------------------------------------|--------------------------|--|
| For calendar plan year 2 | 2016 or fiscal plar | year beginning 01/01/2016 | and er | nding 12/31/2016 | | |
| A Name of plan CANCER CARE NW W | ELFARE BENEF | T PLAN | | e-digit number (PN) | 502 | |
| | | | | | | |
| C Plan sponsor's name as shown on line 2a of Form 5500 CANCER CARE NORTHWEST CENTERS, P.S. | | | | oyer Identification Number 1007627 | (EIN) | |
| | 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 | າ: | | | | | |
| (a) Name of insurance of HARTFORD LIFE AND A | | | | | | |
| 4. FIN | (c) NAIC | (d) Contract or | (e) Approximate number of | Policy or | contract year | |
| (b) EIN | code | identification number | persons covered at end of policy or contract year | (f) From | (g) To | |
| 06-0838648 | 70815 | 767381G | 278 | 01/01/2016 | 12/31/2016 | |
| 2 Insurance fee and co descending order of the | | ation. Enter the total fees and total | commissions paid. List in line 3 | the agents, brokers, and | other persons in | |
| (a) Tota | al amount of comm | · | (b) To | otal amount of fees paid | | |
| | 12658 0 | | | | | |
| 3 Persons receiving co | mmissions and fe | ees. (Complete as many entries a | s needed to report all persons). | | | |
| | | nd address of the agent, broker, o | • | ions or fees were paid | | |
| HUB INTERNATIONAL N | NORTHWEST LL | | K 3144 IE, WA 98220 | | | |
| (b) Amount of sales | and base | Fees | and other commissions paid | | | |
| commissions p | | (c) Amount | (d) Purpose | | (e) Organization code | |
| 12658 | | | | | 3 | |
| | (a) Name a | nd address of the agent, broker, c | or other person to whom commiss | sions or fees were paid | | |
| | ., | • | · | · | | |
| (b) Amount of sales | and base | Fees | and other commissions paid | | | |
| commissions p | | (c) Amount | (d) Purpos | e | (e) Organization code | |
| For Province I Product | ion Act Notice | see the Instructions for Form 55 | 00 | 0.1 | adula A (Form 5500) 2016 | |

| Schedule A (Form 5500) 2 | 2016 | Page 2 – 1 | |
|---|----------------------------------|---|-------------------------|
| (a) No. | me and address of the agent bro | lker, er ether person to whom commissions or fees were paid | |
| (a) Nai | me and address of the agent, bro | oker, or other person to whom commissions or fees were paid | |
| | | Fees and other commissions paid | (e) |
| (b) Amount of sales and base commissions paid | (c) Amount | (d) Purpose | Organization code |
| | | | |
| (a) Nar | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| (a) Nar | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | _ | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| (a) Nar | me and address of the agent, bro | oker, or other person to whom commissions or fees were paid | |
| | | | |

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

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| Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier ma | | | | | | | | |
|---|------|--|---------------------------------------|------------|-----------------------------|--|--|--|
| | | where individual contracts are provided, the entire group of such individual this report. | idual contracts with each carrier may | be treated | d as a unit for purposes of | | | |
| | | ent value of plan's interest under this contract in the general account at year | | 4 | | | | |
| | | rrent value of plan's interest under this contract in separate accounts at year end | | | | | | |
| 6 | Cont | ntracts With Allocated Funds: | | | | | | |
| | а | 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 corretention of the contract or policy, enter amount | nnection with the acquisition or | 6d | | | | |
| | | Specify nature of costs | | | | | | |
| | | | | | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred | d annuity | | | | | |
| | | (3) other (specify) | | | | | | |
| | | | | | | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a terminate | | | | | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | | | | | | |
| | а | Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia | ate participation guarantee | | | | | |
| | | (3) guaranteed investment (4) dother | | | | | | |
| | | | | | | | | |
| | L | | | 71. | | | | |
| | b | Balance at the end of the previous year | | 7b | | | | |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) 7c(2) | | | | | |
| | | (3) Interest credited during the year | 7c(3) | | | | | |
| | | (4) Transferred from separate account | 7c(4) | | | | | |
| | | (5) Other (specify below) | 7c(5) | | | | | |
| | |) | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | (6)Total additions | | 7c(6) | 0 | | | |
| | | Total of balance and additions (add lines 7b and 7c(6)) | | 7d | | | | |
| | | Deductions: | 7.(4) | | | | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | | | | | |
| | | (2) Administration charge made by carrier | 7e(2) 7e(3) | | | | | |
| | | (3) Transferred to separate account | 7e(4) | | | | | |
| | | • | 7.5(4) | | | | | |
| | | , | | | | | | |
| | | | | | | | | |
| | | (5) Total deductions | | 7e(5) | 0 | | | |
| | f | (5) Total deductions | | 76(3) | | | | |
| | | (00000000000000000000000000000000000000 | | | | | | |

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| P | art II | | Welfare Benefit Contract Information | | | | | | |
|----|--------|--------|---|--------------------------|----------------------------|------------------------|----------------|----------|---------------------|
| | | | If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ | ing purposes if such con | tracts are expe | erience-rated as a uni | t. Where cor | ntrac | ts cover individual |
| 8 | Bene | fit ar | nd contract type (check all applicable boxes) | | | | | | |
| | а | He | alth (other than dental or vision) | b Dental | С | Vision | | d X | Life insurance |
| | e X | Ter | mporary disability (accident and sickness) | f X Long-term disabil | itv a \Box | Supplemental unem | | - = | Prescription drug |
| | i E | J | p loss (large deductible) | j HMO contract | | PPO contract | , -, | ıН | Indemnity contract |
| | m | - | ner (specify) | , I invice contract | | 110 contract | | .⊓ | macminy contract |
| | m _ | Oti | iei (specily) | | | | | | |
| 9 | Exnei | rienc | e-rated contracts: | | | | | | |
| | • | | ums: (1) Amount received | | 9a(1) | | | ┪ | |
| | | | crease (decrease) in amount due but unpaid | | | | | ┪ | |
| | , | ٠, | crease (decrease) in unearned premium res | | | | | 1 | |
| | , | ٠, | arned ((1) + (2) - (3)) | | | | . 9a(4) | | |
| | | . , | efit charges (1) Claims paid | | | | | | |
| | (| (2) In | crease (decrease) in claim reserves | | 9b(2) | | | 1 | |
| | (| (3) In | curred claims (add (1) and (2)) | | | | 9b(3) | | |
| | (| (4) C | laims charged | | | | 9b(4) | | |
| | С | Rem | ainder of premium: (1) Retention charges (c | n an accrual basis) | | | | | |
| | | (. | A) Commissions | | 9c(1)(A) | | | ╛ | |
| | | (| B) Administrative service or other fees | | 9c(1)(B) | | | ╛ | |
| | | , | C) Other specific acquisition costs | | | | | 4 | |
| | | , | D) Other expenses | | 9c(1)(D) | | | 4 | |
| | | , | E) Taxes | | | | | 4 | |
| | | | F) Charges for risks or other contingencies. | | 0 (4)(0) | | | 4 | |
| | | , | G) Other retention charges | | | | 00(1)(U) | | |
| | | , | H) Total retention | _ | | | 9c(1)(H) | | |
| | | | vividends or retroactive rate refunds. (These | _ | | | 9c(2) | | |
| | | | us of policyholder reserves at end of year: (1 | | | | 9d(1) | | |
| | | ` ' | claim reserves | | | | 9d(2) 9d(3) | | |
| | | ` ' | other reserveslends or retroactive rate refunds due. (Do n | | | | 9u(3) | | |
| 10 | | | erience-rated contracts: | or include amount entere | u III IIIIe 30(2) . | .) | 36 | | |
| | | | I premiums or subscription charges paid to o | earrier | | | 10a | | 158237 |
| | | | carrier, service, or other organization incur | | | | | | 100201 |
| | | | ntion of the contract or policy, other than rep | , , | | | 10b | | |
| | | | ature of costs. | · | • | | | | |
| | | | | | | | | | |
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| _ | 11 | ., | Dravinian of Information | | | | | | |
| | art I | | Provision of Information | | | | ., г | <u> </u> | |
| | | | nsurance company fail to provide any inform | | lete Schedule | A? | Yes | X N | 0 |
| 12 | If th | e an | swer to line 11 is "Yes," specify the informat | ion not provided. | | | | | |

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

2016

| Pension Benefit Guaranty C | orporation | Insurance companies a pursuant to E | are required to provide t ERISA section 103(a)(2) | | tion | This Fo | rm is Open to Public Inspection |
|--|-------------------|---|--|---------------|-----------------------|----------------|------------------------------------|
| For calendar plan year 20 | 016 or fiscal pla | an year beginning 01/01/2016 | | and er | nding 12/3 | 1/2016 | |
| A Name of plan CANCER CARE NW WE | LFARE BENE | FIT PLAN | | | e-digit number (Pl | N) • | 502 |
| | | | | | | | |
| C Plan sponsor's name | | | | - | - | ation Number | (EIN) |
| CANCER CARE NORTH | WEST CENTE | RS, P.S. | | 91- | 1007627 | | |
| Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information fo 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 c | | | | | | | |
| | ()))) (| 4000 | (e) Approximate number of | | Policy or o | contract year | |
| (b) EIN | (c) NAIC code | (d) Contract or identification number | persons covered a policy or contrac | t end of | (f) | From | (g) To |
| 91-0621480 | 47341 | 00569 | 450 | | 01/01/2016 | 6 | 12/31/2016 |
| 2 Insurance fee and con descending order of th | | nation. Enter the total fees and total | al commissions paid. Li | ist in line 3 | the agents, | brokers, and o | other persons in |
| (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | | | |
| 6057 0 | | | | | | | |
| 3 Persons receiving cor | nmissions and | fees. (Complete as many entries | as needed to report all | persons). | | | |
| | (a) Name | and address of the agent, broker, | or other person to who | m commiss | sions or fees | were paid | |
| MOLONEY AND O'NEILL | LIFE INC. | | ST RIVERSIDE AVE., NE, WA 99201 | STE. 800 | | | |
| (b) Amount of sales a | and base | Fee | es and other commission | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpos | е | | (e) Organization code |
| 6057 | | | | | | | 3 |
| | (a) Name | and address of the agent, broker, | or other person to who | m commiss | sions or fees | were paid | |
| | | | | | | | |
| (b) Amount of sales and base | | Fee | es and other commission | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpos | е | | (e) Organization code |
| | | | | | | | |
| For Denominant Bodinati | on Act Notice | see the Instructions for Form F | EOO | | | Caba | dula A (Farm FEOO) 2016 |

| Schedule A (Form 5500) 2 | 2016 | Page 2 – 1 | |
|---|----------------------------------|---|-------------------------|
| (a) No. | me and address of the agent bro | lker, er ether person to whom commissions or fees were paid | |
| (a) Nai | me and address of the agent, bro | oker, or other person to whom commissions or fees were paid | |
| | | Fees and other commissions paid | (e) |
| (b) Amount of sales and base commissions paid | (c) Amount | (d) Purpose | Organization code |
| | | | |
| (a) Nar | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| (a) Nar | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | _ | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| (a) Nar | me and address of the agent, bro | oker, or other person to whom commissions or fees were paid | |
| | | | |

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

| _ | | • |
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| Part II | | II Investment and Annuity Contract Information | | | |
|---------|------|--|---------------------------------------|------------|-----------------------------|
| | | Where individual contracts are provided, the entire group of such individus this report. | idual contracts with each carrier may | be treated | d as a unit for purposes of |
| | | ent value of plan's interest under this contract in the general account at year | | 4 | |
| | | ent value of plan's interest under this contract in separate accounts at year e | nd | 5 | |
| 6 | Cont | racts With Allocated Funds: | | | |
| | а | 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 corretention of the contract or policy, enter amount | nnection with the acquisition or | 6d | |
| | | Specify nature of costs | | | |
| | | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred | d annuity | | |
| | | (3) other (specify) | | | |
| | | | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a terminate | | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | | | |
| | а | Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia | ate participation guarantee | | |
| | | (3) guaranteed investment (4) dother | | | |
| | | | | | |
| | L | | | 71. | |
| | b | Balance at the end of the previous year | | 7b | |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) 7c(2) | | |
| | | (3) Interest credited during the year | 7c(3) | | |
| | | (4) Transferred from separate account | 7c(4) | | |
| | | (5) Other (specify below) | 7c(5) | | |
| | |) | | | |
| | | | | | |
| | | | | | |
| | | (6)Total additions | | 7c(6) | 0 |
| | | Total of balance and additions (add lines 7b and 7c(6)) | | 7d | |
| | | Deductions: | 7.(4) | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | | |
| | | (2) Administration charge made by carrier | 7e(2) 7e(3) | | |
| | | (3) Transferred to separate account | 7e(4) | | |
| | | • | 7.5(4) | | |
| | | , | | | |
| | | | | | |
| | | (5) Total deductions | | 7e(5) | 0 |
| | f | (5) Total deductions | | 76(3) | |
| | | (00000000000000000000000000000000000000 | | | |

| F | ane | Δ |
|---|-----|---|
| | | |

| Pa | art III | Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individ | group of employees of the ing purposes if such cont | racts are | expe | erience-rated as a ur | nit. Where co | ontracts | cover individual |
|-----|--|--|--|--------------|-------|-----------------------|---------------|----------|-------------------|
| 8 | Benefit a | and contract type (check all applicable boxes) | | | | | | | |
| | а 🗌 н | ealth (other than dental or vision) | b X Dental | (| c 🗌 | Vision | | d 🗌 L | ife insurance |
| | е 🗌 т | emporary disability (accident and sickness) | f Long-term disabili | ty 🤇 | 3 🗌 | Supplemental uner | nployment | h 🗌 P | Prescription drug |
| | i⊟s | top loss (large deductible) | j HMO contract | _ | κΠ | | | ı∏ır | ndemnity contract |
| | = | ther (specify) | , | | Ш | | | ш | , |
| | ⊔ ∨ | the (speelly) | | | | | | | |
| 9 E | Experien | ce-rated contracts: | | | | | | | |
| | | niums: (1) Amount received | | 9a(1) | | | 242409 | 9 | |
| | | ncrease (decrease) in amount due but unpaid | | 9a(2) | | | | | |
| | | ncrease (decrease) in unearned premium res | | 9a(3) | | | | | |
| | | Earned ((1) + (2) - (3)) | | | | | 9a(4) | | 242409 |
| | b Ber | nefit charges (1) Claims paid | | 9b(1) | | | 209630 |) | |
| | (2) ا | ncrease (decrease) in claim reserves | | 9b(2) | | | 1000 |) | |
| | (3) ا | ncurred claims (add (1) and (2)) | | | | | 9b(3) | | 210630 |
| | ` ' | Claims charged | | | | | 9b(4) | | |
| | C Re | mainder of premium: (1) Retention charges (o | n an accrual basis) | | | | | | |
| | | (A) Commissions | | 9c(1)(A | | | 6057 | 7 | |
| | | (B) Administrative service or other fees | | 9c(1)(B | | | 25941 | | |
| | | (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 | | | 00(4)(H) | | 24000 |
| | (0) | (H) Total retention | _ | | _ | | 9c(1)(H) | ' | 31998 |
| | | Dividends or retroactive rate refunds. (These | | , | | | | | |
| | | tus of policyholder reserves at end of year: (1 | • | | | | | | |
| | ` ' | Claim reserves | | | | | | | 7000 |
| | ` ' | Other reserves | | | | | ` ` ` | | |
| 10 | | idends or retroactive rate refunds due. (Do no | ot include amount entered | d in line 90 | (2). | .) | 9e | | |
| | | perience-rated contracts: | orrior | | | | 10a | | |
| | | al premiums or subscription charges paid to c | | | | | 10a | | |
| | | ne carrier, service, or other organization incurrention of the contract or policy, other than repo | | | | | 10b | | |
| ; | | nature of costs. | inted in Fait I, line 2 abov | e, report a | 11110 | unt | 100 | | |
| | | | | | | | | | |
| Pa | rt IV | Provision of Information | | | | | | | |
| 11 | | insurance company fail to provide any inform | ation necessary to esma | loto Sabaa | lula. | Λ ₂ Γ | Yes | X No | |
| | | | | iele Scilec | uie | Λ: | 1 63 | ^ INU | |
| 12 | 2 If the answer to line 11 is "Yes," specify the information not provided. | | | | | | | | |

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

| | | F-4 | = ===================================== | | | | inspection |
|---|-------------------|--|---|----------------|---------------------------|-------------|----------------------------|
| | 16 or fiscal plar | year beginning 01/01/2016 | 1 | and er | | | Г |
| A Name of plan CANCER CARE NW WEL | FARE BENEFI | T PLAN | | B Thre | ee-digit n number (PN) | > | 502 |
| | | | | | , / | | |
| C Plan sponsor's name a | as shown on line | e 2a of Form 5500 | | D Emplo | oyer Identification Nu | ımber (| EIN) |
| CANCER CARE NORTHV | | | | | 1007627 | | |
| | | ning Insurance Contrac Individual contracts grouped a | | | | | |
| 1 Coverage Information: | | - | | | | | |
| | | | | | | | |
| (a) Name of insurance ca VISION SERVICE PLAN | ırrıer | | | | | | |
| | | 10.5 | (e) Approximate num | nber of | Polic | cv or co | ontract year |
| (b) EIN | (c) NAIC code | (d) Contract or identification number | persons covered at end of policy or contract year | | (f) From | o, o. o. | (g) To |
| 23-7089668 | 53031 | 30006545 | 181 | | 01/01/2016 | | 12/31/2016 |
| 2 Insurance fee and com descending order of the | | tion. Enter the total fees and to | tal commissions paid. List | t in line 3 | the agents, brokers, | , and ot | her persons in |
| | amount of comr | nissions paid | | (b) To | otal amount of fees p | oaid | |
| | | 1432 | | • | | | 0 |
| 3 Persons receiving com | missions and fe | es. (Complete as many entries | s as needed to report all pe | ersons). | | | |
| | (a) Name a | nd address of the agent, broker | , or other person to whom | commiss | sions or fees were pa | aid | |
| MOLONEY AND O'NEILL I | LIFE INC. | | EST RIVERSIDE AVE., S | TE. 800 | | | |
| | | SPOR | ANE, WA 99201 | | | | |
| | | | | | | | |
| (b) Amount of sales ar | nd base | Fe | es and other commissions | paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | | | (e) Organization code |
| | 1432 | | | | | | 3 |
| | | | | | | | |
| | | | | | | | |
| | (a) Name a | nd address of the agent, broker | , or other person to whom | commiss | sions or fees were pa | aid | |
| | | | | | | | |
| | | | | | | | |
| | | Fa | es and other commissions | naid | | | |
| (b) Amount of sales ar commissions pa | | (c) Amount | ees and other commissions paid (d) Purpose | | | | (e) Organization code |
| ослинозюна ра | | (o) / arrount | | ., . uipuu | · <u>·</u> | | (5) Organization code |
| | | | | | | | |
| For Panorwark Poductio | n Act Nation | see the Instructions for Form | 5500 | | | Sohor | lule A (Form 5500) 2016 |
| I OF I ADELWOLK NEUDCHO | ハハ へしに けしけしせ、こ | , | JJUU. | | | JUILL | iule A (I UIIII JJUU) 4010 |

| Schedule A (Form 5500) 2 | 2016 | Page 2 – 1 | |
|---|----------------------------------|---|-------------------|
| (a) No. | me and address of the agent bro | lker, er ether person to whom commissions or fees were paid | |
| (a) Nai | me and address of the agent, bro | oker, or other person to whom commissions or fees were paid | |
| | | Fees and other commissions paid | (e) |
| (b) Amount of sales and base commissions paid | (c) Amount | (d) Purpose | Organization code |
| | | | |
| (a) Nar | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | | | |
| (b) Amount of sales and base | | (e) Organization | |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| (a) Nar | me and address of the agent, bro | sker, or other person to whom commissions or fees were paid | |
| | _ | | |
| (b) Amount of sales and base | | Fees and other commissions paid | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| (a) Nar | me and address of the agent, bro | oker, or other person to whom commissions or fees were paid | |
| | | | |

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

| _ | | • |
|-----|---|-----|
| חבע | Δ | - 5 |
| ay | | • |

| Part II | | II Investment and Annuity Contract Information | | | |
|---------|------|--|---------------------------------------|------------|-----------------------------|
| | | Where individual contracts are provided, the entire group of such individus this report. | idual contracts with each carrier may | be treated | d as a unit for purposes of |
| | | ent value of plan's interest under this contract in the general account at year | | 4 | |
| | | ent value of plan's interest under this contract in separate accounts at year e | nd | 5 | |
| 6 | Cont | racts With Allocated Funds: | | | |
| | а | 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 corretention of the contract or policy, enter amount | nnection with the acquisition or | 6d | |
| | | Specify nature of costs | | | |
| | | | | | |
| | е | Type of contract: (1) individual policies (2) group deferred | d annuity | | |
| | | (3) other (specify) | | | |
| | | | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a terminate | | | |
| 7 | Cont | racts With Unallocated Funds (Do not include portions of these contracts ma | | | |
| | а | Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia | ate participation guarantee | | |
| | | (3) guaranteed investment (4) dother | | | |
| | | | | | |
| | L | | | 71. | |
| | b | Balance at the end of the previous year | | 7b | |
| | С | Additions: (1) Contributions deposited during the year | 7c(1) 7c(2) | | |
| | | (3) Interest credited during the year | 7c(3) | | |
| | | (4) Transferred from separate account | 7c(4) | | |
| | | (5) Other (specify below) | 7c(5) | | |
| | |) | | | |
| | | | | | |
| | | | | | |
| | | (6)Total additions | | 7c(6) | 0 |
| | | Total of balance and additions (add lines 7b and 7c(6)) | | 7d | |
| | | Deductions: | 7.(4) | | |
| | | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | | |
| | | (2) Administration charge made by carrier | 7e(2) 7e(3) | | |
| | | (3) Transferred to separate account | 7e(4) | | |
| | | • | 7.5(4) | | |
| | | , | | | |
| | | | | | |
| | | (5) Total deductions | | 7e(5) | 0 |
| | f | (5) Total deductions | | 76(3) | |
| | | (00000000000000000000000000000000000000 | | | |

| F | ane | Δ |
|---|-----|---|
| | | |

| P | art II | | | | | | | |
|----|--------|--|------------------|---------------------|------------------------|-----------------|--------|--------------------|
| | | If more than one contract covers the same group of employees the information may be combined for reporting purposes employees, the entire group of such individual contracts of the contract of the con | f such contracts | are expe | rience-rated as a unit | . Where cor | ntract | s cover individual |
| 8 | Bene | efit and contract type (check all applicable boxes) | | | | | | |
| | а | Health (other than dental or vision) b Dental | | c X | Vision | | d∏ | Life insurance |
| | e 🗀 | | erm disability | _ | Supplemental unemp | olovment | h∏ | Prescription drug |
| | · H | Stop loss (large deductible) | - | | PPO contract | , | 브 | Indemnity contract |
| | | | ontract | ~ □ | 110 contract | | •⊔ | macrimity contract |
| | m | Other (specify) | | | | | | |
| 0 | | | | | | | | |
| | | erience-rated contracts: | | 20/1) | | | - | |
| | | Premiums: (1) Amount received(2) Increase (decrease) in amount due but unpaid | | 9a(1) 9a(2) | | | - | |
| | • | (3) Increase (decrease) in unearned premium reserve | | a(2) | | | 1 | |
| | • | (4) Earned ((1) + (2) - (3)) | <u></u> | | | 9a(4) | | |
| | _ ` | Benefit charges (1) Claims paid | | b(1) | | - σα(+ <i>)</i> | | |
| | | (2) Increase (decrease) in claim reserves | | b(2) | | | _ | |
| | , | (3) Incurred claims (add (1) and (2)) | | | | 9b(3) | | |
| | | (4) Claims charged | | | | 9b(4) | | - |
| | c ì | Remainder of premium: (1) Retention charges (on an accrual b | asis) | | | | | |
| | | (A) Commissions | 9c | (1)(A) | | | | |
| | | (B) Administrative service or other fees | 90 | (1)(B) | | | | |
| | | (C) Other specific acquisition costs | 9c | (1)(C) | | | | |
| | | (D) Other expenses | | (1)(D) | | | | |
| | | (E) Taxes | | (1)(E) | | | _ | |
| | | (F) Charges for risks or other contingencies | | (1)(F) | | | | |
| | | (G) Other retention charges | | (1)(G) | | - (1)(1) | | |
| | | (H) Total retention | _ | _ | | 9c(1)(H) | | |
| | | (2) Dividends or retroactive rate refunds. (These amounts were | | | | 9c(2) | | |
| | d : | Status of policyholder reserves at end of year: (1) Amount held | to provide bene | efits after i | retirement | 9d(1) | | |
| | | (2) Claim reserves | | | | 9d(2) | | |
| | | (3) Other reserves | | | | 9d(3) | | |
| 10 | | Dividends or retroactive rate refunds due. (Do not include amo | unt enterea in i | ine 9c(2) .) |) | 9e | | |
| 10 | | nexperience-rated contracts: Total premiums or subscription charges paid to carrier | | | | 10a | | 31132 |
| | | | | | | IVa | | 31132 |
| | | If the carrier, service, or other organization incurred any specific retention of the contract or policy, other than reported in Part I, | | | | 10b | | |
| | | cify nature of costs. | = 0.5010, 10 | , port arrior | | | | |
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| | | | | | | | | |
| Pa | art I\ | V Provision of Information | | | | | | |
| | | the insurance company fail to provide any information necessa | ry to complete | Schedule . | А? | Yes | X No | D |
| | | he answer to line 11 is "Yes," specify the information not provide | | | <u> </u> | <u>L</u> | | |
| | | | | | | | | |

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Service Provider 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.

| Pension Benefit Guaranty Corporation | 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 |
| CANCER CARE NW WELFARE BENEFIT PLAN | plan number (PN) 502 |
| | |
| | |
| C Plan sponsor's name as shown on line 2a of Form 5500 CANCER CARE NORTHWEST CENTERS, P.S. | D Employer Identification Number (EIN) |
| CANCER CARE NORTHWEST CENTERS, P.S. | 91-1007627 |
| | |
| Part I Service Provider Information (see instructions) | |
| You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in connecti plan during the plan year. If a person received only eligible indirect compensation for whi answer line 1 but are not required to include that person when completing the remainder of | on with services rendered to the plan or the person's position with the ch the plan received the required disclosures, you are required to f this Part. |
| 1 Information on Persons Receiving Only Eligible Indirect Compensa | |
| a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of | |
| indirect compensation for which the plan received the required disclosures (see instruction | s for definitions and conditions) |
| b If you answered line 1a "Yes," enter the name and EIN or address of each person provid received only eligible indirect compensation. Complete as many entries as needed (see in | • . |
| (b) Enter name and EIN or address of person who provided you of | disclosures on eligible indirect compensation |
| | |
| | |
| | |
| (b) Enter name and EIN or address of person who provided you of | disclosures on eligible indirect compensation |
| | |
| | |
| | |
| | |
| | |
| (b) Enter name and EIN or address of person who provided you of | disclosures on eligible indirect compensation |
| | |
| | |
| | |
| | |
| (h) = 1 | |
| (b) Enter name and EIN or address of person who provided you of | disclosures on eligible indirect compensation |
| | |

| Schedule C (Form | 5500) 2016 | Page 2- 1 |
|------------------|--|---|
| (b) | Enter name and EIN or address of person who provided you | disclosures on eligible indirect compensation |
| | | |
| | | |
| (b) | Enter name and EIN or address of person who provided you | disclosures on eligible indirect compensation |
| | | |
| | | |
| (b) | Enter name and EIN or address of person who provided you | disclosures on eligible indirect compensation |
| | | |
| | | |
| (b) | Enter name and EIN or address of person who provided you | disclosures on eligible indirect compensation |
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| | | |
| (b) | Enter name and EIN or address of person who provided you | disclosures on eligible indirect compensation |
| | | |
| | | |
| (b) | Enter name and EIN or address of person who provided you | disclosures on eligible indirect compensation |
| | | |
| (b) | Enter name and EIN or address of person who provided you | disclosures on clinible indirect compensation |
| (6) | Enter hame and Env or address of person who provided you | disclosures on eligible indirect compensation |
| | | |
| (b) | Enter name and EIN or address of person who provided you | disclosures on eligible indirect compensation |
| | | |
| | | |

| ; | Schedule C (Form 550 | 00) 2016 | | Page 3 - 1 | | | | | | |
|--|--|---|---|---|--|---|--|--|--|--|
| 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) | | | | | | |
| PREMERA | BLUE CROSS | | | SPRAGUE AVE NE, WA 99202 | | | | | | |
| 91-049924 | 7 | | | | | | | | | |
| (b) Service Code(s) | Relationship to employer, employer 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? | | | | |
| | ADMIN. SVC. PROVIDER | 180305 | Yes No 🛚 | Yes No | | Yes No | | | | |
| | | (| a) Enter name and EIN or | address (see instructions) | | | | | | |
| 91-062148 | NTAL OF WASHINGT | ON | | RVIEW AVE 800 LE, WA 98109 | | | | | | |
| (b) Service Code(s) | Relationship to employer, employee organization, or person known to be a party-in-interest | 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? | 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? | | | | |
| 13 | ADMIN. SVC. PROVIDER | 25941 | Yes No 🛚 | Yes No | | Yes No No | | | | |
| | | (| a) Enter name and EIN or | address (see instructions) | | | | | | |
| | | | | | | | | | | |
| (b) Service Code(s) | 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? | 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

| Page 3 - | 2 |
|-----------------|---|
|-----------------|---|

| answered | I "Yes" to line 1a above | e, complete as many | entries as needed to list ea | r Indirect Compensation in the person receiving, directly or the plan or their position with the | indirectly, \$5,000 or more in t | total compensation |
|---|--|---|---|--|--|---|
| = | | (| (a) Enter name and EIN or | r address (see instructions) | | |
| | | | | | | |
| (b) Service Code(s) 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 | | | | 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) | | |
| | | | | (0) | | |
| (b) Service Code(s) | 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? | 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) | 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? | 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 No | | Yes No |

| Page 4 - I |
|-------------------|
|-------------------|

Schedule C (Form 5500) 2016

Part I Service Provider Information (continued) If you reported on line 2 receipt of indirect compensation, other than

| If you reported on line 2 receipt of indirect compensation, other than eligible indirect competer provides contract administrator, consulting, custodial, investment advisory, investment magnestions for (a) each source from whom the service provider received \$1,000 or more in information grave you a formula used to determine the indirect compensation instead of an amount and entries as needed to report the required information for each source. | anagement, broker, or recordkeepir | ng services, answer the following ource for whom the service |
|---|---|--|
| (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 | formula used to determine | compensation, including any e the service provider's eligibilit 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 | formula used to determine | compensation, including any e the service provider's eligibilit 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 | formula used to determine | t compensation, including any e the service provider's eligibilit the indirect compensation. |
| | | |

| Part | II Service Providers Who Fail or Refuse to I | Provide Inform | mation |
|------|---|-------------------------------------|---|
| | Provide, to the extent possible, the following information for each his Schedule. | ch service provide | r who failed or refused to provide the information necessary to complete |
| (8 | 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 |
| | | | |
| | | | |
| (8 | 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 |
| | | | |
| (8 | 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 |
| | | | |
| (8 | 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 |
| | | | |
| (8 | 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 |
| | | | |

| Page 6 - | l |
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Schedule C (Form 5500) 2016

| Pa | art III | Termination Information on Accountants and Enrolled Actuaries (see in (complete as many entries as needed) | structions) |
|----------|--------------|--|---------------------|
| а | Name: | | b EIN: |
| С | Position | | |
| d | Address | | e Telephone: |
| <u> </u> | 71001000 | • | Telephone. |
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| | planation: | | |
| LX | piariatiori. | | |
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| | | | |
| | | | |
| a | Name: | | b EIN: |
| С | Position | | |
| d | Address | : | e Telephone: |
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| Ex | planation: | | |
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| a | Name: | | b EIN: |
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| | Nome | | b EIN: |
| <u>a</u> | Name: | | D EIN. |
| C | Position | | A.T. I. |
| d | Address | ; | e Telephone: |
| | | | |
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| Ex | planation: | | |
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| а | Name: | | b EIN: |
| С | Position | | |
| d | Address | | e Telephone: |
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| | nlone#!=: | | |
| ĽΧ | planation: | | |
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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 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

v. 160205

2016

This Form is Open to Public Inspection

| Part I Annual Report Id | entification Information | | | | |
|---|--|--|-------------------------|---|---------------|
| For calendar plan year 2016 or fise | cal plan year beginning 0.3 | 1/01/2016 | and ending 1: | 2/31/2016 | |
| A This return/report is for: | a multiemployer plan | a multiple-employ | er plan (Filers checkin | | ch a list of |
| | | _ participating emp | loyer information in ac | cordance with the f | orm instr.) |
| X | a single-employer plan | a DFE (specify) _ | | | |
| B This return/report is: | the first return/report | the final return/re | port | | |
| | an amended return/report | | return/report (less tha | n 12 months) | |
| If the plan is a collectively-bargain | The state of the s | | | ▶∐ | |
| | Form 5558 | automatic extens | ion | VC program | |
| | special extension (enter descrip nation - enter all requested info | | | *************************************** | |
| 1a Name of plan | ration - enter all requested into | ormation | dt. Thur | 1' -'4 | |
| CANCER CARE NW WELF | יאסה פראההדת סואי | т | | e-digit number (PN) | 502 |
| CANCER CARE IN WELL | ARE DENEFTI FOAT | V | | tive date of plan | 504 |
| | | | | /01/2008 | |
| 2a Plan sponsor's name (employer, if for | r a single-employer plan) | | | oyer Identification N | umber (FIN) |
| Mailing address (include room, apt., s | | | | -1007627 | ambor (Eliv) |
| City or town, state or province, countr | ry, and ZIP or foreign postal code (if | foreign, see instructions) | | Sponsor's telephone | e number |
| CANCER CARE NORTHWE | ST CENTERS, P.S. | ************************************** | | 28-1000 | |
| | | | 2d Busin | ness code (see instru | uctions) |
| | | | 621 | 1111 | |
| 1204 N. VERCLER, ST | E.101 | | | | |
| | 00016 | | | | |
| SPOKANE VALLEY | WA 99216 | | | | |
| | | | | | |
| Caution: A penalty for the late or inc | complete filing of this return/re | enort will be assessed u | nless reasonable car | usa is astablished | |
| Under penalties of perjury and other penalties set for | | | | | mente ae well |
| as the electronic version of this return/report, and to | | | | noo, olatorromo and attaorn | monto, do won |
| 11 13 | 1.1 | | | | |
| SIGN Merren Deum | icas 10/8/2 | | BENINCOSA | | |
| Signature of plan administra | tor Date | Enter name of | individual signing as | plan administrator | |
| SIGN / Beren J. Bourn | 10/9/2017 | | | | |
| HERE | 1 | WARREN | BENINCOSA | | |
| Signature of employer/plan s | sponsor Date | Enter name of | individual signing as | employer or plan spo | onsor |
| SIGN | | | | | |
| HERE Signature of DFE | Date | Enter name of | individual signing as | DEE | |
| Preparer's name (including firm name, | | | | | |
| Treparer s hame (including lim hame, | , il applicable) alla address (ilici | ade room of saite nambe | n) Prep | arer's telephone nur | nber |
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| | | | | | |
| For Paperwork Reduction Act Notice | see the Instructions for Forn | EEOO | | - | EE00 (0046) |

| _ | Form 5500 (2016) | | | | Р | age 2 | | | | |
|----|--|--------------|---------|-----------|----------|--|-----------|----------|--------------------|------------|
| За | Plan administrator's name and address 🗵 Same as Plan Sponsor | | | | | 3b Add | | | EIN telephone n | umber |
| 4 | If the name and/or EIN of the plan sponsor has changed since the last EIN and the plan number from the last return/report: | return/repo | rt fi | led for t | this pla | n, enter th | he nam | ne, | 4b EIN | |
| а | Sponsor's name | | | | | | | | 4c PN | |
| 5 | Total number of participants at the beginning of the plan year | | | | | | Т | 5 | | 219 |
| 6 | Number of participants as of the end of the plan year unless otherwise | stated (wel | fare | plans | comple | te only lin | nes | | | |
| | 6a(1), 6a(2), 6b, 6c, and 6d). | | | | | | | | | |
| а | (1) Total number of active participants at the beginning of the plan year | r | | | | | | 6a(1) | | 219 |
| a | (2) Total number of active participants at the end of the plan year | | | | | | | 6a(2) | | 214 |
| D | Retired or separated participants receiving benefits | | | | | ••••• | | 6b | | |
| | Other retired or separated participants entitled to future benefits | | | | | | | 6c 6d | | 21.4 |
| e | Subtotal. Add lines 6a(2), 6b, and 6c Deceased participants whose beneficiaries are receiving or are entitled | to receive | | ofite | | | | 6e | | 214 |
| f | Total. Add lines 6d and 6e | | | | | | | 6f | | |
| g | Number of participants with account balances as of the end of the plar | n vear (only | def | ned co | ntributi | on plans | | | | |
| | complete this item) | | | | | | | 6g | | |
| h | Number of participants that terminated employment during the plan ye | ar with acci | uec | benefi | ts that | were less | than | | | |
| | 100% vested | | | | | | | 6h | | |
| 7 | Enter the total number of employers obligated to contribute to the plan | (only multie | emp | loyer p | lans | | | | | |
| _ | complete this item) | | | | | | | 7 | | |
| 8a | If the plan provides pension benefits, enter the applicable pension feat | ure codes f | om | the Lis | t of Pla | n Charac | teristic | s Cod | es in the ins | tructions: |
| | | | | | | | | | | |
| b | If the plan provides welfare benefits, enter the applicable welfare featur | re codes fro | m ti | no Liet | of Plan | Characto | riotico | Codo | a in the inetu | |
| 4A | 4B 4D 4E 4F 4H | e codes no | III U | IE LISU | oi Piari | Characte | ristics | Codes | s in the instr | uctions: |
| | | | | | | | | | | |
| 9a | Plan funding arrangement (check all that apply) | 9b Plan | ber | efit arra | angeme | ent (check | k all tha | at app | ly) | 1000 |
| | (1) X Insurance | | X | | | To the second se | | | ,, | |
| | (2) Code section 412(e)(3) insurance contracts | (2) | Ц | Code | section | n 412(e)(3 |) insur | ance c | ontracts | |
| | (3) Trust | (3) | Ц | Trust | | | | | | |
| | (4) X General assets of the sponsor | (4) | | | | ets of the | | | | |
| 10 | Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions) | are attache | d, a | and, wh | ere ind | icated, er | nter the | e numb | oer attached | I. |
| 2 | # 9-28-500 (COLE FOUR 19-28-50) (Printer) | b Gen | | . 0 - 1 | | | | | | |
| а | Pension Schedules (1) R (Retirement Plan Information) | | era | Sched | | (C:: | -11-6- | | | |
| | (2) MB (Multiemployer Defined Benefit Plan and Certain Money | (1) | Н | | н | (Financia | | | , | > |
| | Purchase Plan Actuarial Information) - signed by the plan | | X | 3 | I A | (Insuran | | | n - Small Pla | (1) |
| | actuary | (3) (4) | X | | C | | | | ormation) | |
| | (3) SB (Single-Employer Defined Benefit Plan Actuarial | (5) | M | | D | | | | an Informati | on) |
| | Information) - signed by the plan actuary | (6) | | | G | | | | n Schedules | |
| | | | | | | . A | | | | |

| Part III | Form M-1 Compliance Information (to be completed by welfare benefit plans) |
|----------|--|
| CFF | e plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 R 2520.101-2.) Yes X No Yes" is checked, complete lines 11b and 11c. |
| | ne plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No er 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 |
| ente | er the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failur nter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) |
| Rec | eipt Confirmation Code |