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

2018

This Form is Open to Public

			Inspection
Part I Annual Report	Identification Information		
	fiscal plan year beginning 01/01/201	18 and ending 12/31/2	018
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking	
Transcration, open is ion		participating employer information in acco	rdance with the form instructions.)
	a single-employer plan	a DFE (specify)	
B This return/report is:	the first return/report	the final return/report	
	an amended return/report	a short plan year return/report (less than 1	2 months)
C If the plan is a collectively-ba	rgained plan, check here		
D Check box if filing under:	Form 5558	automatic extension	the DFVC program
	X special extension (enter descri	ription) SEE ATTACHED REQUEST FOR RELIEF	
Part II Basic Plan Info	ormation—enter all requested info	ormation	
1a Name of plan CANCER CARE NW WELFAR	E BENEFIT PLAN		1b Three-digit plan number (PN) ▶ 502
			1c Effective date of plan 01/01/2008
Mailing address (include roo City or town, state or provin	oyer, if for a single-employer plan) om, apt., suite no. and street, or P.O ce, country, and ZIP or foreign posta		2b Employer Identification Number (EIN) 91-1007627
CANCER CARE NORTHWEST	CENTERS, P.S.		2c Plan Sponsor's telephone number 509-228-1000
1204 N VERCLER STE 101 SPOKANE VALLEY, WA 99216	STE	4 N VERCLER 101 KANE VALLEY, WA 99216	2d Business code (see instructions) 621111
		/report will be assessed unless reasonable cause	
Under penalties of perjury and of	other penalties set forth in the instruc	tions, 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. Signature of plan administrator	10/14/2019 Date	SUSAN LEPTICH Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2018) v. 171027

Page 2 Form 5500 (2018) **3a** Plan administrator's name and address X Same as Plan Sponsor **3b** Administrator's EIN 3c Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN a Sponsor's name c Plan Name 5 Total number of participants at the beginning of the plan year 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1),

	6a(2), 6b, 6c, and 6d).						
a	1) Total number of active participants at the beginning of the plan year					6a(1)	223
a(2) Total number of active participants at the end of the plan year					6a(2)	214
b	Retired or separated participants receiving benefits					6b	
С	Other retired or separated participants entitled to future benefits					6с	
d	Subtotal. Add lines 6a(2), 6b, and 6c					6d	214
е	Deceased participants whose beneficiaries are receiving or are entitled to rece	eive be	nefits			6e	
f	Total. Add lines 6d and 6e					6f	214
g	Number of participants with account balances as of the end of the plan year (o complete this item)	-				6g	
h	Number of participants who terminated employment during the plan year with a less than 100% vested					6h	
7	Enter the total number of employers obligated to contribute to the plan (only m	nultiem	oloyer p	lans	complete this item)	7	
b	If the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4B 4D 4E 4F 4H 4Q	s from	the List	of P	lan Characteristics Codes	s in the ir	estructions:
9a 10	(1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor	(* (* (* (*	1) 2) 3) 4)	X	Insurance Code section 412(e)(3) Trust General assets of the sp	insurance oonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are atta	acneu,	and, w	nere	indicated, enter the numb	er allaci	ied. (See instructions)
а	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	(Seneral 1) 2) 3) 4)	Sch	H (Financial Inform I (Financial Inform 3 A (Insurance Inform C (Service Provide	nation – S mation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	•	5) 6)		D (DFE/ParticipatiG (Financial Trans	_	

Form 5500 (2018)

Page 3

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)						
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt 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 Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code						

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

2018

		pursuant to Ef	RISA section 103(a)(2).				Inspection
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan CANCER CARE NW WELFARE BENEFIT PLAN				B Three	e-digit number (PI	N) •	502
C Plan sponsor's name a CANCER CARE NORTH					yer Identific 1007627	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca VISION SERVICE PLAN	rrier						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nur persons covered at			Policy or co	ontract year I
(5) EIIV	code	identification number	policy or contract		(f)	From	(g) To
23-7089668	53031	30006545	179		01/01/2018	8	12/31/2018
2 Insurance fee and come descending order of the		tion. Enter the total fees and total	I commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comn	·		(b) To	otal amount	of fees paid	
		1365					
3 Persons receiving com		es. (Complete as many entries a					
ALLIANT INSURANCE SE		nd address of the agent, broker, of 701 B S	•	commiss	ions or fees	were paid	
ALLIANT INSURANCE SE	KVIOLO		EGO, CA 92101-8156				
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai	id	(c) Amount	(0	d) Purpose	Purpose		(e) Organization code
	1365						3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai	id	(c) Amount	(0	d) Purpose	e		(e) Organization code
<u> </u>	- A-(N-(i	see the leastwestians for Forms 55	-00			0-1	Iula A (Farm FF00) 2049

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part					
		Where individual contracts are provided, the entire group of such indivi	idual contracts	s with each carrier may	be treated	d as a unit for purposes of
_	_	this report.		T		
		rent 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	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		-		
	u	retention of the contract or policy, enter amount.		= -	6d	
		Specify nature of costs				
		openity hattare or 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 termin	ating plan sh	eck here		
_						
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ite participatio	n guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
				Г	71-	
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(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
	d	Total of balance and additions (add lines 7b and 7c(6)).	·····		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		L Carlot (epoolity bolotty)				
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		-	7f	0
	•					

Р	art	III Welfare Benefit Contract Inform	ation					
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same than the contract covers the same the contract covers the	ting purposes if such conti	racts are exp	erience-rated as a ur	nit. Where co	ontracts cover indiv	
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance	e
	_ L	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	Supplemental uner	mploymont	h Prescription	
	e		<u> </u>		_	прюуттети		-
	ı	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity co	ntract
	m	Other (specify)						
9		erience-rated contracts:	į					
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpai		9a(2)				
		(3) Increase (decrease) in unearned premium res		9a(3)		0 (0)		
	L	(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves				01- (0)		
		(3) Incurred claims (add (1) and (2))						
	_	(4) Claims charged				9b(4)		
	С	, , , , , , , , , , , , , , , , , , , ,	,	0c(1)(A)				
		(A) Commissions		9c(1)(A) 9c(1)(B)				
		(B) Administrative service or other fees (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.		- (1)(-)				
		(G) Other retention charges						
		(H) Total retention				9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)			
	d	Status of policyholder reserves at end of year: (*	_	_				
	_	(2) Claim reserves	•			9d(2)		
		(3) Other reserves						
	е	Dividends or retroactive rate refunds due. (Do n						
10	No	nexperience-rated contracts:		•				
	а	Total premiums or subscription charges paid to	carrier			10a		31018
	b	If the carrier, service, or other organization incur	red any specific costs in c	onnection wit	th the acquisition or			
	_	retention of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	cify nature of costs.						
_	ort.	IV Provision of Information						
	art				F		<u> </u>	
		the insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No	
12	lf t	he answer 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

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

2018

		pursuant to E	RISA section 103(a)(2)).			Inspection
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan CANCER CARE NW WEI	LFARE BENEF	IT PLAN		B Three-digit plan number (PN) 502			
C Plan sponsor's name a				-	yer Identific 1007627	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
(In) [IN]	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
91-0621480	47341	00569	378	3	01/01/2018	3	12/31/2018
2 Insurance fee and com- descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and o	her persons in
(a) Total a	amount of comm	·		(b) To	otal amount	of fees paid	
		5391					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
ALLIANT INSURANCE SE	RVICES/CORK	STE 80	RIVERSIDE AVE 0 .NE, WA 99201				
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code
	5391						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code
Can Danamuant Daduatia	n Aat Natics :	see the Instructions for Farms 5	E00			Calaa	Ila A (Farm FF00) 2040

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part					
		Where individual contracts are provided, the entire group of such indivi	idual contracts	s with each carrier may	be treated	d as a unit for purposes of
_	_	this report.		T		
		rent 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	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		-		
	u	retention of the contract or policy, enter amount.		= -	6d	
		Specify nature of costs				
		openity hattare or cooks				
	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 termin	ating plan sh	eck here		
_						
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	ite participatio	n guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
				Г	71-	
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(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
	d	Total of balance and additions (add lines 7b and 7c(6)).	·····		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		L Carlot (epoolity bolotty)				
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		-	7f	0
	•					

P	Part III	Welfare Benefit Contract Inform				
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same that individual to the contract covers the same the information of the covers the same that individual to the covers the covers the covers the same that individual to the covers the co	ting purposes if such con	tracts are expe	erience-rated as a unit. Where c	contracts cover individual
8	Benefit	and contract type (check all applicable boxes)				
	a ∏ ⊦	Health (other than dental or vision)	b X Dental	с□	Vision	d Life insurance
		emporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unemployment	h Prescription drug
	- =		j HMO contract		PPO contract	I Indemnity contract
		Stop loss (large deductible)	I HIVIO CONTIACT	^ _	FFO Contract	
	m 📙 (Other (specify)				
_						
9	•	nce-rated contracts:		0-(4)		_
		miums: (1) Amount received			23263	3
	` '	Increase (decrease) in amount due but unpai				_
		Increase (decrease) in unearned premium res			92(4)	23263
	_ ` '	Earned ((1) + (2) - (3)) enefit charges (1) Claims paid			9a(4)	
		- · · · · · · · · · · · · · · · · · · ·		21 (2)	-400	
	` '	Increase (decrease) in claim reserves Incurred claims (add (1) and (2))				19168
	. ,	Claims charged				10100
	` '	emainder of premium: (1) Retention charges (00(4)	
	•	(A) Commissions	,	9c(1)(A)	539	1
		(B) Administrative service or other fees		- (1)(-)	2461	
		(C) Other specific acquisition costs		0 (4)(0)		
		(D) Other expenses		0 (4)(D)		_
		(E) Taxes		9c(1)(E)		
		(F) Charges for risks or other contingencies.		9c(1)(F)		
		(G) Other retention charges		9c(1)(G)		
		(H) Total retention			9c(1)(H	3000
	(2)	Dividends or retroactive rate refunds. (These	e amounts were paid in	n cash, or	credited.)9c(2)	
	d Sta	atus of policyholder reserves at end of year: (I) Amount held to provide	benefits after	retirement 9d(1)	
	(2)	Claim reserves			9d(2)	500
	(3)	Other reserves			9d(3)	
	e Div	vidends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2) .) 9e	
10	Nonex	perience-rated contracts:				
	a To	tal premiums or subscription charges paid to	carrier		10a	
	ret	he carrier, service, or other organization incur ention of the contract or policy, other than rep nature of costs.			•	
	b If t	he carrier, service, or other organization incur	red any specific costs in o	connection with	h the acquisition or	
	art IV	Provision of Information		Jaka Cali - Ji I	ло П Voo	M No.
		e insurance company fail to provide any inform		lete Schedule	A? Yes	X No
12	If the a	answer 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

2018

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Form is Open to Public Inspection							
For calendar plan year 20	18 or fiscal pla	n year beginning 01/01/2018		and en	nding 12/3	1/2018	
A Name of plan CANCER CARE NW WEI	FARE BENEF	FIT PLAN			e-digit number (PI	N) •	502
C Plan sponsor's name a CANCER CARE NORTH					oyer Identific 1007627	ation Number	(EIN)
		rning Insurance Contract Individual contracts grouped as					
(a) Name of insurance ca HARTFORD LIFE AND AC							
(b) EIN (c) NAI code		(d) Contract or identification number	(e) Approximate nu persons covered a policy or contrac	t end of	(f)	From	(g) To
06-0838648 70815 767381G 247 01/01/2018 12/31/2018						12/31/2018	
2 Insurance fee and complete descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, and	other persons in
	amount of com	missions paid		(b) To	otal amount	of fees paid	
		11843				'	
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).			
		and address of the agent, broker,		m commiss	ions or fees	were paid	
HUB INTERNATIONAL NO	ORTHWEST LL		X 3144 NE, WA 98220				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	11843						3
	(a) Name a	and address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
							adula A (Form FF00) 2048

Schedule A (Form 5500) 2018	Page 2 – 1		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
			(5)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
	T		(e)	
(b) Amount of sales and base		Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	, 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) Na				
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization	
commissions paid	(0)	(4) - 3-1-2-3	code	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
	T			
	•	Fees and other commissions paid		
(b) Amount of sales and base		·	(e) Organization	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
		·	Organization	

F	Part				
		Where individual contracts are provided, the entire group of such indiv	idual contracts w	ith each carrier may be treat	ed as a unit for purposes of
_	_	this report.			1
		ent value of plan's interest under this contract in the general account at year			
		ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in co		and visition or	
	u	retention of the contract or policy, enter amount.		·	
		Specify nature of costs			1
		opeony natare or costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		_			
	f	If contract numbered in whole or in part to distribute honefite from a termin	otina plan, chool	thoro	
_		If contract purchased, in whole or in part, to distribute benefits from a termin			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а	Type of contract: (1) deposit administration (2) immedia	ate participation g	guarantee	
		(3) guaranteed investment (4) other			
				71-	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits			
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
)			
					_
	_	(6)Total additions			0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	7e(4)		
		\(\frac{1}{2} = \frac{1}{2} \f			
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0
		, (

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or	the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. 8 Benefit and contract type (check all applicable boxes) a	the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. 8 Benefit and contract type (check all applicable boxes) a	P	art III	Welfare Benefit Contract Inform				
a	a	a			the information may be combined for repor	ting purposes if such con	tracts are expe	erience-rated as a unit. Where of	contracts cover individual
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract I ☐ Indemnity contract m ☐ Other (specify) ►AD&D 9 Experience-rated contracts: a Premiums: (1) Amount received	e	e	8	Benefit	and contract type (check all applicable boxes)				
i	i	i		а	Health (other than dental or vision)	b Dental	С	Vision	d X Life insurance
i	i	i				f \ \ Long-term disabil	itv a	Supplemental unemployment	- H
## State of the specify → NASAD Experience-rated contracts: a Premiums: (1) Amount received	## Status of policy of the reserves. ## Other (specify) ▶ AD&D Experience-rated contracts: a Premiums: (1) Amount received	## Discrete (Specify) ▶ AD&BD ## Discrete (Specify) ▶ AD&BD		- =		_	· - <u>-</u>		<u> </u>
Experience-rated contracts: a Premiums: (1) Amount received	B Experience-rated contracts: a Premiums: (1) Amount received	B Experience-rated contracts: a Premiums: (1) Amount received		=) [Time contract		1 1 O contract	I I Indemnity contract
a Premiums: (1) Amount received	a Premiums: (1) Amount received	a Premiums: (1) Amount received		III X	Other (specify) PAD&D				
a Premiums: (1) Amount received	a Premiums: (1) Amount received	a Premiums: (1) Amount received	0	Cynoria	and rated contractor				
(2) Increase (decrease) in amount due but unpaid	(2) Increase (decrease) in amount due but unpaid	(2) Increase (decrease) in amount due but unpaid	J	•			02/1)		_
(3) Increase (decrease) in unearned premium reserve 9a(3) 9a(4) (4) Earned ((1) + (2) - (3))	(3) Increase (decrease) in unearned premium reserve	(3) Increase (decrease) in unearned premium reserve			` '				
(4) Earned ((1) + (2) - (3)) Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2)) (4) Claims charged C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges (F) Charges for risks or other contingencies (B) Other retention charges (C) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) (C) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) Polity of the carrier, service, or other organization incurred any specific costs in connection with the acquisition or	(4) Earned ((1) + (2) - (3))	(4) Earned ((1) + (2) - (3)) 9a(4) b Benefit charges (1) Claims paid 9b(1) (2) Increase (decrease) in claim reserves 9b(2) (3) Incurred claims (add (1) and (2)) 9b(3) (4) Claims charged 9b(4)		•	, , ,				
b Benefit charges (1) Claims paid	b Benefit charges (1) Claims paid	b Benefit charges (1) Claims paid						9a(4)	
(2) Increase (decrease) in claim reserves	(2) Increase (decrease) in claim reserves	(2) Increase (decrease) in claim reserves		_ `					
(3) Incurred claims (add (1) and (2)) (4) Claims charged	(3) Incurred claims (add (1) and (2))	(3) Incurred claims (add (1) and (2))					21 (2)		
(4) Claims charged	(4) Claims charged	(4) Claims charged		•	` '			9b(3)	
(A) Commissions 9c(1)(A) (B) Administrative service or other fees 9c(1)(B) (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) (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a 14	(A) Commissions	(A) Commissions		, ,	, , , , , , , , , , , , , , , , , , , ,				
(B) Administrative service or other fees	(B) Administrative service or other fees	(B) Administrative service or other fees		C R	emainder of premium: (1) Retention charges (on an accrual basis)		<u> </u>	
(C) Other specific acquisition costs (D) Other expenses	(C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges (H) Total retention (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) (2) Claim reserves (3) Other reserves (3) Other retenced contracts: a Total premiums or subscription charges paid to carrier b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	(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)(F) (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a 14803 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b			(A) Commissions		9c(1)(A)		
(D) Other expenses	(D) Other expenses	(D) Other expenses			(B) Administrative service or other fees				
(E) Taxes	(E) Taxes	(E) Taxes			(C) Other specific acquisition costs				
(F) Charges for risks or other contingencies	(F) Charges for risks or other contingencies	(F) Charges for risks or other contingencies			(D) Other expenses				
(G) Other retention charges	(G) Other retention charges	(G) Other retention charges							_
(H) Total retention	(H) Total retention	(H) Total retention					0 (1)(0)		
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a 1480 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount 10b	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)			` ,			00/1//L	7/
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier 10a 14 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or	d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves		(0	` '	_			
(2) Claim reserves	(2) Claim reserves	(2) Claim reserves							- 1
(3) Other reserves	(3) Other reserves	(3) Other reserves							
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier	e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier		`	,				
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier	10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier	10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier		•	•				
a Total premiums or subscription charges paid to carrier	Total premiums or subscription charges paid to carrier	Total premiums or subscription charges paid to carrier	10			or morade amount entere	a iii iiiic 30(2) .	.,	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or	b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount				carrier		10a	148039
	retention of the contract or policy, other than reported in Part I, line 2 above, report amount	retention of the contract or policy, other than reported in Part I, line 2 above, report amount			, , , , , , , , , , , , , , , , , , , ,				1.0000
,				re	tention of the contract or policy, other than rep	, ,			
			P	art IV	Provision of Information				
Part IV Provision of Information	Part IV Provision of Information	Part IV Provision of Information						10 No.	V No
Part IV Provision of Information							lete Schedule	A? Yes	NO NO
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	11 Did the insurance company fail to provide any information necessary to complete Schedule A?	11 Did the insurance company fail to provide any information necessary to complete Schedule A?	12	If the	answer to line 11 is "Yes," specify the information	ion not provided.			

Cancer Care Northwest

Plan Name: Centers PS EIN: 91-1007627 Plan Number: 502

Explanation for late filing

Due to a change in auditors, we missed filing Form 5500 on July 31, 2019, for 2018 plan year. As soon as we discovered this omission, we immediately made arrangements to prepare the return for filing. We are filing the return today. We regret this error as we take this filing obligation very seriously. We have modified our internal processes so this error will not happen again.

We respectfully request that you consider this return as having been filed timely and waive any penalties.

Thank you for your consideration.