### Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and 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-SF.

OMB Nos. 1210-0110 1210-0089

2017

This Form is Open to Public Inspection

Parti	Annuai Repor	t identification information							
For calenda	ar plan year 2017 or	fiscal plan year beginning 11/01/2	2017	and ending 10/	/31/2018				
A This ret	urn/report is for:	x a single-employer plan		olan (not multiemployer) (F mployer information in acc		-			
<b>D</b>		a one-participant plan	a foreign plan						
<b>B</b> This retu	ırn/report is	the first return/report	the final return/report						
		x an amended return/report	a short plan year retu	rn/report (less than 12 mo	nths)				
C Check b	oox if filing under:	Form 5558	automatic extension		DFVC pro	gram			
		special extension (enter desc	• •						
Part II	Basic Plan Inf	ormation—enter all requested in	formation						
1a Name HEMATOLO	•	SY ASSOCIATES OF RHODE ISLA	ND, INC. CASH BALANCE	E PLAN	1b Three- plan nu (PN)	umber	02		
					1c Effective	ve date of plan 11/01/2006			
		loyer, if for a single-employer plan)			<b>2b</b> Employ	er Identification N	lumber		
	g address (include ro town, state or provir	tructions)	(EIN)	05-0475195					
-	GY AND ONCOLOG	il delions)	2c Spons	or's telephone nun 401-943-4660	nber				
					2d Busine	ss code (see instru	uctions)		
1220 PONTIA CRANSTON,						621111			
CITAINSTON,	, IXI 02920								
3a Plan a	dministrator's name	and address X Same as Plan Spo	nsor.		<b>3b</b> Admini	strator's EIN			
		_		_	20 Admin	-1111			
					<b>3C</b> Admini	strator's telephone	e number		
		he plan sponsor or the plan name honsor's name, EIN, the plan name			<b>4b</b> EIN	05-0472881			
		LOGY & ONCOLOGY ASSOCIATE	•		4d PN	002			
C Plan N	ame HEMATOLOGY	AND ONCOLOGY ASSOCIATES	OF RHODE ISLAND CAS	H BALANCE PLAN					
<b>5a</b> Total r	number of participant	s at the beginning of the plan year.			5a		21		
<b>b</b> Total r	number of participant	s at the end of the plan year			5b		21		
		account balances as of the end of		-	5c				
<b>d(1)</b> Tota	al number of active p	articipants at the beginning of the p	lan year		5d(1)		17		
<b>d(2)</b> Tota	al number of active p	articipants at the end of the plan ye	ar		5d(2)		17		
		o terminated employment during the			5e		0		
Caution: A	penalty for the late	or incomplete filing of this retur	n/report will be assessed	d unless reasonable caus					
SB or Sche		other penalties set forth in the instru and signed by an enrolled actuary, a nplete.							
SIGN	Filed with authorize	d/valid electronic signature.	07/09/2020	PLAYKIL JOSEPH					
HERE	Signature of plan	administrator	Date	Enter name of individu	al signing as	plan administrato	or		
SIGN									
HERE Signature of employer/plan sponsor Date Enter name of indiv				Enter name of individu	vidual signing as employer or plan sponsor				

Form 5500-SF 2017 Page **2** 

b	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)									
	If "Yes" is checked, enter the My PAA confirmation number from th		-					Not determined . (See instructions.)		
Pa	rt III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning o	of Year			(b) End	of Year		
а	Total plan assets	7a	295	51315				3090568		
b	Total plan liabilities	7b		0				0		
С	Net plan assets (subtract line 7b from line 7a)							3090568		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) -	Γotal		
<u>а</u>	Contributions received or receivable from: (1) Employers	8a(1)		0						
	(2) Participants	8a(2)		0	_					
	(3) Others (including rollovers)	8a(3)	16	57327	_					
<u>b</u>	Other income (loss)	8b								
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						167327		
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	2	28074						
е	Certain deemed and/or corrective distributions (see instructions)	8e		0						
f	Administrative service providers (salaries, fees, commissions)	8f	0							
g	Other expenses									
<u>h</u>	1 Total expenses (add lines 8d, 8e, 8f, and 8g)							28074		
<u>_i</u>	i Net income (loss) (subtract line 8h from line 8c)							139253		
<u>j</u>	Transfers to (from) the plan (see instructions)									
Pa	t IV Plan Characteristics									
9a	If the plan provides pension benefits, enter the applicable pension 1A 1C	feature co	des from the List of Pla	an Cha	racteri	stic Co	des in the ins	tructions:		
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	les from the List of Plan	n Chara	acterist	ic Cod	es in the instr	uctions:		
Par	t V Compliance Questions									
10	During the plan year:				Yes	No		Amount		
а	Was there a failure to transmit to the plan any participant contribu described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	iduciary Correction	10a		X				
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not	include transactions	10b		X				
С				10c		Χ				
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		Х				
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)					X				
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		X				
g			•	10g		Χ				
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)			10h		X				
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i						

Form 5500-SF 2017	Page <b>3-</b> 1
-------------------	------------------

Part	VI Pension Funding Compliance								
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sc (Form 5500) and line 11a below)		8B	X	es No				
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a			0				
Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?									
а	<b>a</b> If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver								
lf :	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.								
b	Enter the minimum required contribution for this plan year	. 12b							
С	Enter the amount contributed by the employer to the plan for this plan year	. 12c							
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d							
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No	N/A				
Part	VII Plan Terminations and Transfers of Assets								
13a	Has a resolution to terminate the plan been adopted in any plan year?		X Yes	S No	ı				
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a			(				
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	e		Yes X	No				
C If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)									
1	<b>13c(1)</b> Name of plan(s): 13c(	2) EIN(s)		13c(3)	PN(s)				

## **SCHEDULE SB** (Form 5500)

Department of the Treasury Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

## Single-Employer Defined Benefit Plan **Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

2017

OMB No. 1210-0110

This Form is Open to Public Inspection

	, ,	File as an	attachment to Form	5500 or 5	500-SF.			
For ca	lendar plan year 2017 or fiscal pla	n year beginning 11/0	1/2017		and ending	10/31	/2018	
▶ Ro	und off amounts to nearest dolla	ar.						
▶ Ca	ution: A penalty of \$1,000 will be a	assessed for late filing of th	is report unless reason	able caus	e is established.			
	ne of plan				B Three-digit			
HEN PLA	MATOLOGY AND ONCOLOGY AS N	SOCIATES OF RHODE IS	SLAND, INC. CASH BA	LANCE	plan numb	er (PN)	<b>)</b>	002
C Plar	n sponsor's name as shown on line	2a of Form 5500 or 5500-	 SF		<b>D</b> Employer Io	lentificat	tion Number (E	IN)
	MATOLOGY AND ONCOLOGY AS					05-0475	,	,
<b>E</b> Type	e of plan: X Single Multiple-A	A Multiple-B	<b>F</b> Prior year pla	an size: 🗙	100 or fewer	101-5	00 More th	an 500
Part	t I Basic Information							
1 E	nter the valuation date:	Month Day	Year					
<b>2</b> A	ssets:				_			
а	Market value					2a		3118642
b	Actuarial value					2b		3118642
<b>3</b> F	unding target/participant count bre	akdown		` '	umber of icipants		ed Funding arget	(3) Total Funding Target
а	For retired participants and benef	iciaries receiving payment.			0		0	0
b	For terminated vested participant	s			7		47278	47278
С	For active participants				15		2354277	2354277
d	Total				22		2401555	2401555
<b>4</b> If	the plan is in at-risk status, check	the box and complete lines	s (a) and (b)					
а	Funding target disregarding preso	cribed at-risk assumptions				4a		
b	Funding target reflecting at-risk as at-risk status for fewer than five or					4b		
5 E	ffective interest rate	<u> </u>				5		5.65 %
<b>6</b> T	arget normal cost					6		354629
Statem	ent by Enrolled Actuary					•		
acco	ne best of my knowledge, the information suppordance with applicable law and regulations. In bination, offer my best estimate of anticipated	n my opinion, each other assumption	ying schedules, statements an i is reasonable (taking into acc	d attachment ount the expe	s, if any, is complete a rience of the plan and	nd accura reasonabl	te. Each prescribed e expectations) and	assumption was applied in d such other assumptions, in
SIC	3N							
HE							12/20/201	8
		gnature of actuary			· -		Date	
MAR	K VIDAL	g					17-05069	)
		or print name of actuary			· -	Most re	cent enrollmer	nt number
THE HILB GROUP OF NEW ENGLAND, LLC				800-678-1700				
		Firm name			Tele	phone r	number (includ	ing area code)
	JEFFERSON BOULEVARD E 3001							,
WAR	RWICK, RI 02886							
	ļ.	Address of the firm						
If the ac	tuary has not fully reflected any re	gulation or ruling promulgat	ted under the statute in	completin	na this schedule	check tl	ne box and see	<u> </u>
instruction		Januaria or running promitingat	aa.i iilo olalalo III	. Jonipiotii	oonoaaio,	5OOK U		- 📙

Page 2	? - ·
--------	-------

Schedule SB (Form 5500) 2017

P	art II	Begir	nning of Year	Carryov	er and Prefunding B	alances						
	'						(a)	Carryover balance		(b) P	refundir	ig balance
7		•	0 ,		able adjustments (line 13 fro			C				0
8			•	•	nding requirement (line 35 f			C				0
9	Amount	remainin	g (line 7 minus line	8)			0 0					
10	Interest	on line 9	using prior year's	actual retu	rn of%			C				0
11	Prior yea	ar's exces	s contributions to	be added	to prefunding balance:				_			
				`	38a from prior year)	-						0
					a over line 38b from prior ye interest rate of5.790							0
	` ,		•	•	edule SB, using prior year's							0
	<b>C</b> Total a	vailable a	t beginning of curre	ent plan yea	ar to add to prefunding balanc	e						0
	<b>d</b> Portio	n of (c) to	be added to pref	unding bala	ance							0
12	12 Other reductions in balances due to elections or deemed elections							0				
					line 10 + line 11d – line 12)			C				0
Р	Part III Funding Percentages											
14	14 Funding target attainment percentage											
	15 Adjusted funding target attainment percentage								15	129.85%		
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement						current	16	124.01%				
17	If the cur	rent valu	e of the assets of	the plan is	less than 70 percent of the	funding targe	et, enter s	uch percentage			17	%
	Part IV Contributions and Liquidity Shortfalls											
18					ar by employer(s) and employer			1 000		1 ,		
(1)	<b>(a)</b> Dat √M-DD-Y		(b) Amount p employer		(c) Amount paid by employees	<b>(a)</b> [ (MM-DD		(b) Amount pa employer(		(c) Amount paid by employees		
						Totals ▶	18(b)		(	18(c)		
19	Discount	ed emplo	over contributions	_ see instr	uctions for small plan with a					10(0)		0
15			•		num required contributions t				l9a			0
	_				usted to valuation date				l9b			0
				•	red contribution for current ye				l9c			0
20			itions and liquidity		•	<u> </u>						
	a Did th	e plan ha	ive a "funding sho	rtfall" for th	e prior year?							Yes X No
	<b>b</b> If line	20a is "Y	es," were required	d quarterly	installments for the current	year made in	a timely	manner?				Yes No
	C If line	20a is "Y	es," see instructio	ns and cor	nplete the following table as	applicable:						
		(4)			Liquidity shortfall as of en	d of quarter of	•	· .	1			
		(1) 1s	t		(2) 2nd		(3)	3rd	-	(	4) 4th	

P	art V	Assumpti	ons Used to Determ	ine Funding Target	and Targ	jet Normal Cost				
21	Discount	rate:								
	<b>a</b> Segmo	ent rates:	1st segment: 4.16%	2nd segmer 5.72		3rd segment: 6.48 %		N/A, full yield curve used		
	<b>b</b> Applica	able month (er	nter code)				21b	0		
22	Weighted	d average retire	ement age				22	62		
23	Mortality	table(s) (see i	instructions) X F	Prescribed - combined	Preso	ribed - separate	Substitu	ute		
Pa	art VI	Miscellane	ous Items							
24		•	·	nctuarial assumptions for th		•				
25	Has a me	ethod change b	been made for the current	plan year? If "Yes," see in	structions re	egarding required attach	ment	Yes X No		
26	Is the pla	n required to p	provide a Schedule of Activ	ve Participants? If "Yes," s	ee instruction	ons regarding required a	ittachmen	tYes 🛚 No		
27				enter applicable code and s			27			
Р	Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years									
	3 Unpaid minimum required contributions for all prior years						28	0		
29							29	0		
30	Remaining amount of unpaid minimum required contributions (line 28 minus line 29)					30	0			
Pa	Part VIII Minimum Required Contribution For Current Year									
31										
	<b>a</b> Target normal cost (line 6)									
	<b>b</b> Excess assets, if applicable, but not greater than line 31a									
32	32 Amortization installments: Outstanding Ba						nce	Installment		
	a Net sho	ortfall amortiza	ation installment				0	0		
							0	0		
33	If a waive (Month _			enter the date of the ruling) and the waived			33			
34	Total fund	ding requireme	ent before reflecting carryo	ver/prefunding balances (I	ines 31a - 3	1b + 32a + 32b - 33)	34	0		
				Carryover bala	ince	Prefunding balan	ice	Total balance		
35			se to offset funding		0		0	0		
36	Additiona	al cash require	ment (line 34 minus line 35	5)			36	0		
37	Contribut	ions allocated	toward minimum required	contribution for current yea	ar adjusted	to valuation date (line	37	0		
38			s contributions for current							
	<b>a</b> Total (e	excess, if any,	of line 37 over line 36)				38a	0		
				of prefunding and funding s			38b	0		
39	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						39	0		
40	40 Unpaid minimum required contributions for all years									
Pa	rt IX	Pension	Funding Relief Unde	er Pension Relief Ac	ct of 2010	(See Instructions	<u> </u>			
41	If an elec	tion was made	to use PRA 2010 funding	relief for this plan:						
	<b>a</b> Schedu	ule elected						2 plus 7 years 15 years		
	<b>b</b> Eligible	plan year(s) f	for which the election in lin	e 41a was made			20	08 2009 2010 2011		
42	Amount o	of acceleration	adjustment				42			
43	Excess in	stallment acce	eleration amount to be carr	ied over to future plan vea	rs		43			

#### Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and 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-SF.

1210-0089

2017

OMB Nos. 1210-0110

This Form is Open to Public Inspection

Do-4	Annual Dance	4 1-14161 - 41 - 1 6 41							<del></del>	
Part I	Annual Repor	rt Identification Information fiscal plan year beginning		01/0015		<del></del>				
TO Caleriu	lai pian year 2017 or	_		01/2017		and ending		31/2018		
A This re	tum/report is for:	X a single-employer plan	∐a⊪ — <sup>‼i</sup>	multiple-emplist of participa	loyer pl iting en	an (not multiemployer) nployer information in a	(Filers chec ccordance	king this bo	x must attach a n instructions.)	
_		a one-participant plan	a	foreign plan					·	
B This ret	tum/report is	the first return/report	☐ th	e final return/	report					
		X an amended return/report	a	short plan ye	ar retur	n/report (less than 12 n	nonths)			
C Check	box if filing under:	Form 5558		utomatic exte	nsion		DFVC	orogram		
		special extension (enter desc								
Part II	Basic Plan Inf	formation—enter all requested in	nformati	on			·			
1a Name	•	LOGY ASSOCIATES OF RH	IODE ]	ISLAND,	INC.	CASH BALANCE	1b Three	number	002	
PLAN							1c Effe	ctive date o	f plan	
Mailing	g address (include ro	loyer, if for a single-employer plan) om, apt., suite no. and street, or P.	O. Box)		-	······································	2b Emp		fication Number	
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) HEMATOLOGY AND ONCOLOGY ASSOCIATES OF RHODE ISLAND, INC.						ructions)	2c Spo	<u> </u>	hone number	
1220 PONTIAC AVENUE							2d Business code (see instructions) 621111			
CRANSTO	ON	RI 02920								
3a Plan administrator's name and address X Same as Plan Sponsor.						3b Adm	inistrator's I	EIN		
							3c Adm	inistrator's t	telephone number	
4 If the r	name and/or EIN of than, enter the plan sp	he plan sponsor or the plan name honsor's name, EIN, the plan name	nas char	nged since the	e last re	eturn/report filed for ne last return/report.	4b EIN	4b EIN <sub>05-0472881</sub>		
		ology & Oncology Asso					4d PN	002		
C Plan N	ame Hematol	logy and Oncology Associat	es of	Rhode Isl	and C	ash Balance Plan				
5a Total r	number of participant	s at the beginning of the plan year.					5a		21	
		s at the end of the plan year					5b		21	
		account balances as of the end of					5c			
<b>d(1)</b> Tota	a) number of active p	articipants at the beginning of the p	olan year	r	•••••	•••••	5d(1)		17	
		articipants at the end of the plan ye					5d(2)		17	
than t	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested						0			
Linder pens	penalty for the late	or incomplete filing of this return the instruction of the instruction	m/repor	t will be ass	essed (	unless reasonable car	use is estal	blished.	abla a Cabadala	
SB or Sche	edule MB completed a true, correct, and con	and signed by an enrolled actuary,	as well a	as the electro	nic ven	sion of this return/repor	t, and to the	best of my	knowledge and	
SIGN	X	emy		,	,	Playkil Joseph	1			
HERE	Signature of plan	57 administrator		Date 79	20	Enter name of individ	ual signing :	as plan adn	ninistrator	
SIGN					-			E		
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or pla				er or plan sponsor						

Form	EEO	CE	201	7
LOIII	ວວເກ	トント	/111	1

Page 2

6a	Were all of the plan's assets during the plan year invested in eligit	ble assets	? (See instructions.)					X Ye	es $\square$ No
b	Are you claiming a waiver of the annual examination and report of	an indepe	endent qualified public	accour	tant (I	OPAL			S   NO
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility	and cond	tions.)					X Ye	es No
	If you answered "No" to either line 6a or line 6b, the plan can	not use Fo	orm 5500-SF and mu	st inste	ead us	e Forn	n 5500.		
·	If the plan is a defined benefit plan, is it covered under the PBGC i	nsurance	orogram (see ERISA s	section	4021)?	· L	Yes X No	☐ Not de	etermined
	If "Yes" is checked, enter the My PAA confirmation number from the	ne PBGC p	premium filing for this	plan ye	ar			(See inst	ructions.)
Pa	rt III   Financial Information								
7	Plan Assets and Liabilities		(a) Beginning	of Yea	r		(b) End	of Year	
	Total plan assets	. 7a	2	,951,	315			3,0	090,56
b	Total plan liabilities	7b			0				1
c	Net plan assets (subtract line 7b from line 7a)	7c	2	,951,	315			3,0	090,56
8	Income, Expenses, and Transfers for this Plan Year		(a) Amou	nt			(b)	Total	
a	Contributions received or receivable from: (1) Employers	8a(1)			0				
	(2) Participants	8a(2)			0				
	(3) Others (including rollovers)	8a(3)		167,	327				
b	Other income (loss)	8b							
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						1	67,32
d	Benefits paid (including direct rollovers and insurance premiums								
	to provide benefits)	8d	28,074						
	Certain deemed and/or corrective distributions (see instructions)	8e	0						
	Administrative service providers (salaries, fees, commissions)	8f	0						
	Other expenses	8g		0					
	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						28,074	
	Net income (loss) (subtract line 8h from line 8c)	8i					1	39,253	
		8j			0				
	t IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 1A 1C								
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	es from the List of Pla	n Chara	acteris	tic Cod	les in the instri	uctions:	
Par	t V Compliance Questions								
10	During the plan year:				Yes	No		Amount	
а	Was there a failure to transmit to the plan any participant contribu	tions within	n the time period						
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	iduciary Correction	40-		х			
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not i	nclude transactions	10a 10b		х			
С	Was the plan covered by a fidelity bond?			10c		Х			
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	fidelity bor	nd, that was caused	10d		Х			
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.).			10e		х			
f	Has the plan failed to provide any benefit when due under the plan			10f					
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of year-e	nd.)	10g		Х			
h	If this is an individual account plan, was there a blackout period? (2520.101-3.)	See instru	ctions and 29 CFR	10h		х			
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101	e required	notice or one of the	10ii					

Form	5500-SF	2017
------	---------	------

Page	3-	

Part	VI Pension Funding Compliance					
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and (Form 5500) and line 11a below)	complete Sch	edule S	В	X Ye	es 🗌 No
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		11a		0	
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the CERISA?  (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	ode or section	n 302 o	f	Ye	es X No
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see insgranting the waiver.	Month	enter		of the letter Year	ruling
H	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line	13.				
b	Enter the minimum required contribution for this plan year		12b			
c	Enter the amount contributed by the employer to the plan for this plan year		12c			
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the negative amount)		12d		-	
<u>e</u>	Will the minimum funding amount reported on line 12d be met by the funding deadline?			Yes	No	N/A
Part '	VII Plan Terminations and Transfers of Assets					
13a	Has a resolution to terminate the plan been adopted in any plan year?			X Yes	☐ No	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year		13a			0
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brougentrol of the PBGC?	ght under the		[	Yes X	No
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident which assets or liabilities were transferred. (See instructions.)	ify the plan(s)	to			
1	3c(1) Name of plan(s):	13c(2)	EIN(s)		13c(3)	PN(s)
-		<del> </del>				
						<del></del>

## **SCHEDULE SB** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Single-Employer Defined Benefit Plan Actuarial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

File as an attachment to Form 5500 or 5500-SF.

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning $11/01/2017$		and ending		10/31/20	18
Round off amounts to nearest dollar.					
▶ Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reas	onable cau	se is established	-		
A Name of plan HEMATOLOGY AND ONCOLOGY ASSOCIATES OF RHODE ISLAND CASH BALANCE PLAN	D, INC.	B Three-dig plan numl		•	002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF		D Employer I	dentifica	ition Number (E	IN)
					············
Hematology and Oncology Associates of Rhode Island	d, Inc.	05-0475195	5		
	plan size: 🛭	100 or fewer	101-5	More that	an 500
Part I Basic Information		·			
1 Enter the valuation date: Month 10 Day 31 Year	2018			776 where the second second	
2 Assets:					
a Market value	•••••		2a	<del>,</del>	3,118,642
<b>b</b> Actuarial value			2b		3,118,642
3 Funding target/participant count breakdown	1 ( )	Number of rticipants	` '	ted Funding Farget	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment		0		0	0
<b>b</b> For terminated vested participants		7		47,278	47,278
C For active participants		15	15 2,354,277 2		
<b>d</b> Total		. 22	2	2,401,555	2,401,555
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)		7			
a Funding target disregarding prescribed at-risk assumptions	_		4a	Personal Section Section 1992 Section 1992	
<b>b</b> Funding target reflecting at-risk assumptions, but disregarding transition rule for status for fewer than five consecutive years and disregarding loading factor	plans that h	ave been in at-ris	4h		
5 Effective interest rate			5		5.65%
6 Target normal cost			6		354,629
Statement by Enrolled Actuary		2			
To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into combination, offer my best estimate of anticipated experience under the plan.	s and attachmen account the exp	nts, if any, is complete perience of the plan an	and accura d reasonal	ate. Each prescribed ble expectations) and	assumption was applied in such other assumptions, in
SIGN HERE				12/20/20	18
Signature of actuary				Date	-
MARK VIDAL				1705069	
Type or print name of actuary	•			ecent enrollmer 800-678-1	
THE HILB GROUP OF NEW ENGLAND, LLC					
Firm name		Tel	epnone	number (includi	ng area code)
931 JEFFERSON BOULEVARD SUITE 3001					
WARWICK RI 02886 Address of the firm		<del>-</del>			
If the actuary has not fully reflected any regulation or ruling promulgated under the statute	e in complet	ing this schedule	, check	the box and see	•
instructions  For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-5	SF.			Schedule SI	3 (Form 5500) 2017

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

	Schedi	ule SB (F	orm 5500) 2017			Pag	e <b>2 +</b>					
P	art II	Begir	ning of Year	Carryov	er and Prefunding Ba	lances						
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)						(a) C	arryover balance	0	(b) P	refundi	ng balance
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior											
9									0			(
10						-			0			
11	The latest of time of using prior year of detail retain or the prior year of year of the prior year of the prior year of year											
	•											(
	a Present value of excess contributions (line 38a from prior year)											
	• •		•	•	edule SB, using prior year's a	ctual						
					ar to add to prefunding balance							
	_				ance							
12					or deemed elections				0			C
					line 10 + line 11d – line 12)				0			
	Part III		ding Percenta		mic to time true mic 12)				<u> </u>			
		_		•							14	129.85%
					e						15	129.85%
16	Prior yea	r's fundir	g percentage for p	ourposes	of determining whether carry	over/prefundi	ng balance	es may be used to r	educe cu		16	124.01%
17	If the cur	rent valu	e of the assets of	he plan is	less than 70 percent of the f	unding target	, enter suc	ch percentage			17	%
P	art IV	Con	tributions and	d Liquic	lity Shortfalls							
18	Contribut	ions mad			ear by employer(s) and emplo	yees:						
(1	(a) Date MM-DD-Y		(b) Amount pa employer(		(c) Amount paid by employees	( <b>a)</b> Da (MM-DD-)		(b) Amount pai employer(s		(с		nt paid by oyees
	22	,	ep.eye.	,	op.oyeee	( 22	,	p.eye.(e	,		ор.	-,
						Totals ▶	18(b)		0	18(c)		C
19	Discount	ed omele	wer contributions	see inst	ructions for small plan with a	valuation data		heginning of the ve	ar.		<u> </u>	
13			-		mum required contributions fr				9a			C
b Contributions made to avoid restrictions adjusted to valuation date												
C Contributions allocated toward minimum required contribution for current year adjusted to valuation date												
20			tions and liquidity									
a Did the plan have a "funding shortfall" for the prior year?												
	<b>b</b> If line 2	20a is "Y	es," were required	quarterly	installments for the current y	ear made in a	a timely m	anner?			∏	Yes No
	C If line 2	20a is "Y	es," see instruction	ns and co	mplete the following table as	applicable:	-					
					Liquidity shortfall as of end							
		(1) 1s	t		(2) 2nd		(3)	3rd		(	4) 4th	1

F	Part V	Assumpti	ons Used to Determine	e Funding Target and Targ	jet Normal Cost					
21	21 Discount rate:									
					3rd segment: 6.48%		N/A, full yield curve used			
	<b>b</b> Applicable month (enter code)						0			
22	Weighted	average retire	ement age			22	62			
23	Mortality	able(s) (see	instructions) X Pres	cribed - combined Preso	ribed - separate	Substitu	ite			
Pa	art VI	Miscellane	ous Items							
24	24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment									
25	Has a me	thod change b	been made for the current plar	n year? If "Yes," see instructions re	egarding required attacl	nment	Yes 🗓 No			
26	Is the pla	n required to p	provide a Schedule of Active P	Participants? If "Yes," see instruction	ons regarding required a	attachment	t Yes 🗓 No			
27		-	_	r applicable code and see instructi		27				
Р	art VII	Reconcilia	ation of Unpaid Minim	um Required Contribution	s For Prior Years					
28	Unpaid m	inimum requir	red contributions for all prior ye	ears		28	0			
29				unpaid minimum required contribut		29	0			
30	Remainin	g amount of u	inpaid minimum required conti	ributions (line 28 minus line 29)		30	0			
P	art VIII	Minimum	Required Contribution	For Current Year						
31	Target no	ormal cost and	d excess assets (see instruction	ons):						
	<b>a</b> Target r	normal cost (li	ne 6)			31a	354,629			
	<b>b</b> Excess	assets, if app	licable, but not greater than lir	ne 31a		31b	354,629			
32	Amortizat	ion installmen	its:		Outstanding Bala	ınce	Installment			
	a Net sho	ortfall amortiza	ation installment			0	0			
						0	0			
33	If a waive (Month _		· · · · · · · · · · · · · · · · · · ·	er the date of the ruling letter granti ) and the waived amount		33				
34	Total fund	ling requireme	ent before reflecting carryover	/prefunding balances (lines 31a - 3	1b + 32a + 32b - 33)	. 34	0			
				Carryover balance	Prefunding balar	nce	Total balance			
35			se to offset funding	0		0	0			
36	Additiona						0			
37							0			
38	38 Present value of excess contributions for current year (see instructions)									
	a Total (excess, if any, of line 37 over line 36)									
	<b>b</b> Portion	included in lir	38b	0						
39	Unpaid m	inimum requir	39	0						
40	40 Unpaid minimum required contributions for all years						0			
Pa	Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)									
41	41 If an election was made to use PRA 2010 funding relief for this plan:									
	<b>a</b> Schedu	le elected				<u>.                                </u>	2 plus 7 years 15 years			
	<b>b</b> Eligible	plan year(s) f	for which the election in line 41	la was made		20	08 2009 2010 2011			
42	Amount o	facceleration	adjustment			42				
43	Excess in	stallment acce	eleration amount to be carried	over to future plan years	<del></del>	43				