## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

**Annual Report Identification Information** 

Part I

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).

2016

This Form is Open to Public Inspection

OMB Nos. 1210-0110

1210-0089

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

A This return/report is for:  a single-employer plan  a multiple-employer plan (not multiemployer) (Filers checking this box must a list of participating employer information in accordance with the form instruct a foreign plan  B This return/report is  the first return/report  an amended return/report  an amended return/report  an animended return/report  an automatic extension  DFVC program  part II Basic Plan Information—enter all requested information  1a Name of plan  CENTRAL WASHINGTON SLEEP DISORDERS CENTER, PC 401K PLAN				
B This return/report is				
an amended return/report a short plan year return/report (less than 12 months)  C Check box if filing under:				
an amended return/report a short plan year return/report (less than 12 months)  C Check box if filing under:				
special extension (enter description)  Part II Basic Plan Information—enter all requested information  1a Name of plan CENTRAL WASHINGTON SLEEP DISORDERS CENTER, PC 401K PLAN  1b Three-digit plan number				
Part II Basic Plan Information—enter all requested information  1a Name of plan CENTRAL WASHINGTON SLEEP DISORDERS CENTER, PC 401K PLAN  1b Three-digit plan number				
1a Name of plan CENTRAL WASHINGTON SLEEP DISORDERS CENTER, PC 401K PLAN  1b Three-digit plan number				
CENTRAL WASHINGTON SLEEP DISORDERS CENTER, PC 401K PLAN plan number				
	001			
1c Effective date of plan 01/01/2005	1c Effective date of plan			
2a Plan sponsor's name (employer, if for a single-employer plan)  Mailing address (include room, apt., suite no. and street, or P.O. Box)  2b Employer Identification I (EIN) 91-1682421	Number			
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  CENTRAL WASHINGTON SLEEP DISORDERS CLINIC  2c Sponsor's telephone nu 509-452-5378	mber			
2d Business code (see inst	ructions)			
111 UNIVERSITY PARKWAY 621111	luctions)			
SUITE 103 YAKIMA, WA 98901				
<b>3a</b> Plan administrator's name and address ☐ Same as Plan Sponsor.  91-1682421				
CENTRAL WASHINGTON SLEEP DISORDERS CLINIC 111 UNIVERSITY PARKWAY SUITE 103  3C Administrator's telephor	e number			
YAKIMA, WA 98901 509-452-5378				
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the 4b EIN				
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.  a Sponsor's name  4b EIN  4c PN				
name, EIN, and the plan number from the last return/report.	Ę			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN	Ę			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year				
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	2			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	4			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	4			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	2			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year	2 3 4 Schedule			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	2 3 4 Schedule			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year	Schedule			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  4c PN  5a Total number of participants at the beginning of the plan year	Schedule			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	Schedule dge and			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	Schedule dge and			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	Schedule dge and			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	Schedule dge and			
name, EIN, and the plan number from the last return/report.  a Sponsor's name  5a Total number of participants at the beginning of the plan year	Schedule dge and			

Form 5500-SF 2016 Page **2** 

b	Were all of the plan's assets during the plan year invested in eligib Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility	an indepe	ndent qualified public a	account	ant (IC	PA)			X Yes	
	If you answered "No" to either line 6a or line 6b, the plan canr					_	_	_		
C I	f the plan is a defined benefit plan, is it covered under the PBGC ir	nsurance p	orogram (see ERISA se	ection 4	021)?		Yes	No	Not dete	rmined
Par	t III Financial Information		Ī							
7	Plan Assets and Liabilities		(a) Beginning					(b) End	of Year	
	Total plan assets	7a	1	003352					1078449	
	Total plan liabilities	7b		000050					1070110	
C	Net plan assets (subtract line 7b from line 7a)	7c	1	003352					1078449	
	ncome, Expenses, and Transfers for this Plan Year		(a) Amour	nt	_			(b) 1	Γotal	
	Contributions received or receivable from: (1) Employers	8a(1)		4224						
	(2) Participants	8a(2)		14333						
	(3) Others (including rollovers)	8a(3)								
	Other income (loss)	8b		73382						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							91939	
	Benefits paid (including direct rollovers and insurance premiums	00								
	to provide benefits)	8d		226						
е	Certain deemed and/or corrective distributions (see instructions).	8e								
f_	Administrative service providers (salaries, fees, commissions)	8f								
g	Other expenses	8g		16616						
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							16842	
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i							75097	
j	Transfers to (from) the plan (see instructions)	8j								
Par	t IV Plan Characteristics									
	If the plan provides pension benefits, enter the applicable pension 2E $$ 2J $$ 2K $$ 3D									
b	If the plan provides welfare benefits, enter the applicable welfare f	eature cod	les from the List of Pla	n Chara	acteris	tic Cod	des in t	he instr	uctions:	
Part	V Compliance Questions									
10	During the plan year:				Yes	No	N/A		Amount	
а	Was there a failure to transmit to the plan any participant contribudescribed in 29 CFR 2510.3-102? (See instructions and DOL's \Program)	oluntary F	iduciary Correction	10a		X				
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)			10b		X				
С	Was the plan covered by a fidelity bond?			10c	X					120000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		X				
е	Were any fees or commissions paid to any brokers, agents, or otl carrier, insurance service, or other organization that provides son the plan? (See instructions.)	her person ne or all of	s by an insurance the benefits under	10e		X				
f	Has the plan failed to provide any benefit when due under the plan	an?		10f		X				
g	Did the plan have any participant loans? (If "Yes," enter amount a	as of year-	end.)	10g		X				
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 t exceptions to providing the notice applied under 29 CFR 2520.10	he require	d notice or one of the	10i						

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Page 3-	1	
Page 3-	1	

Part	VI	Pension Funding Compliance					
11		s a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and constructions and constructions and constructions and constructions and constructions and constructions are supplied to the constructions and constructions are supplied to the constructions are supplied to the construction and construction are supplied to the construction are supplied to the construction and construction are supplied to the construction and construction are supplied to the construction and construction are supplied to the construction are supplied to the construction and construction are supplied to the construction and construction are supplied to the constru					es No
11a	Ente	r the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		. 11a			
12		is a defined contribution plan subject to the minimum funding requirements of section 412 of the Co			f		es X No
	ERIS (If "\	A?				🖰	
а		raiver of the minimum funding standard for a prior year is being amortized in this plan year, see inst ing the waiver		nd enter t Day		of the lette Year _	r ruling
lf	you co	ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 1	3.				
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			
	Subt	ract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the letive amount)	eft of a	12d			
е	Will t	he 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	a resolution to terminate the plan been adopted in any plan year?			Yes	s X N	0
	If "Y€	es," enter the amount of any plan assets that reverted to the employer this year		. 13a			
b		e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or broug		e 		Yes X	No
С		rring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identif h assets or liabilities were transferred. (See instructions.)	fy the plan(	s) to			
	13c(1)	Name of plan(s):	13c(2	<b>2)</b> EIN(s)		13c(3	<b>)</b> PN(s)
Part	VIII	Trust Information					
14a	Name	of trust		14b	Trust's E	ΞIN	
14c	Name	of trustee or custodian				s or custodi ne number	an's
Par	t IX	IRS Compliance Questions					
15a	Is the	plan a 401(k) plan? If "No," skip b	Yes			No	
15b		did the plan satisfy the nondiscrimination requirements for employee deferrals under section (3) for the plan year? Check all that apply:		gn-based harbor	d [	Prior ye test	ar" ADP
			Gur ADP	rent year test	,"	N/A	
16a		testing method was used to satisfy the coverage requirements under section 410(b) for the plan Check all that apply:	Rat perd test	centage		verage enefit test	□ N/A
16b		ne plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) be plan year by combining this plan with any other plan under the permissive aggregation rules?	Yes			No	
	the le		<u> </u>				
	letter		nter the date	e of the n	nost rec	ent determi	nation
18	Were	ed Benefit Plan or Money Purchase Pension Plan Only: any distributions made during the plan year to an employee who attained age 62 and had not sepa		Ye	s [	No	
19	Was	any plan participant a 5% owner who had attained at least age 70 $\frac{1}{2}$ during the prior plan year?	•••••	. Ye	s	No	

## 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

2016

OMB Nos. 1210-0110 1210-0089

This Form is Open to Public Inspection

Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500-SF.

Part I		t Identification Information			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
For calend	lar plan year 2016 or		01/01/2016	and ending	12/31/2			
A This re	drum/ramantia favo	X a single-employer plan	a multiple-employer pl	lan (not multiemployer)	(Filers checking th	is box must attach a		
A Inis re	turn/report is for:	a one-participant plan	a foreign plan	nployer information in a	ccordance with the	form instructions.)		
			a loreign plan					
B This ret	urn/report is	the first return/report	the final return/report					
		an amended return/report		rn/report (less than 12 n	months)			
C Observe	La contraction of the second			inteport (icos tilai) 12 il	ionus)			
C Check	box if filing under:	区 Form 5558	automatic extension		DFVC progran	n		
		special extension (enter descrip						
Part II		ormation—enter all requested infor	mation					
1a Name	**				1b Three-digit			
CENTRAL	WASHINGTON S	SLEEP DISORDERS CENTER,	PC 401K PLAN		plan numbe	er 001		
						ate of plan		
					01/01/20			
2a Plan s	ponsor's name (empl	loyer, if for a single-employer plan)				dentification Number		
Mailin	g address (include ro r town, state or provin	om, apt., suite no. and street, or P.O. lice, country, and ZIP or foreign postal	Box)	ruotiono)	(EIN)91-3			
CENTRA	L WASHINGTON	SLEEP DISORDERS CLINIC		ructions)	2c Sponsor's f	telephone number		
					509-452-			
	IVERSITY PARK	YAW				ode (see instructions)		
SUITE ,	100/03				621111			
YAKIMA		WA 98901						
		and address 🗌 Same as Plan Spons	or.		3b Administrate			
CENTRAL	WASHINGTON S	SLEEP DISORDERS CLINIC			91-1682421			
111 TINT	VERSITY PARKV	J73.37			3C Administrate 509-452-5	or's telephone number		
SUITE 1		IAI			309-452-3	3378		
YAKIMA	7,2	WA 98901						
	name and/or EIN of th	ne plan sponsor has changed since the	e last return/report filed f	or this plan, enter the	4b EIN			
name	, EIN, and the plan ກເ	umber from the last return/report.	- instruction of post mod it	or the plan, enter the	4D EII4			
	or's name				4c PN			
5a Total	number of participant	s at the beginning of the plan year			5a	5		
		s at the end of the plan year			. 5b	4		
C Numb	er of participants with	account balances as of the end of the	e plan year (only defined	contribution plans	5c			
						4		
		articipants at the beginning of the plan			. 5d(1)	3		
Q(Z) 10t	ar number of active pr	articipants at the end of the plan year.			5d(2)	2		
than	100% vested	t terminated employment during the pl			5e	0		
Caution: A	l penalty for the late	or incomplete filing of this return/re	eport will be assessed	unless reasonable car	use is established	<u>0</u> d.		
SB or Sche	alties of perjury and o edule MB completed a	ther penalties set forth in the instruction and signed by an enrolled actuary, as	ons, I declare that I have	examined this return/re	port, including, if a	pplicable, a Schedule		
belief, it is t	rue correct, and com	plete.	wen as the electronic ver	sion of this returninepor	t, and to the best o	r my knowledge and		
SIGN 8/14/17 GEOFFREY GREENBERG								
HERE	Signature of plan	administrator	Date	Enter name of individ	ual signing as plan	administrator		
SIGN					ad olgrang do plan	daministrator		
HERE	Signature of emplo	over/plan sponsor	Date	Enter name of individ		1		
Preparer's	name (including firm	name, if applicable) and address (inclu	ude room or suite numbe	Enter name of individer )	Preparer's teleph			
						mannoo		

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Page 2

b	Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility. If you answered "No" to either line 6a or line 6b, the plan cannot lift the plan is a defined benefit plan, is it covered under the PBGC in	an independ and condition ot use Forr	lent qualified public ans.) ns.) n 5500-SF and mus	accoun st inste	tant (IC	QPA) e Forn	n 5500.	
_	rt III Financial Information					L.		
7	Plan Assets and Liabilities		(a) Beginning	of Yea	r		-	b) End of Year
а	Total plan assets	7a		003,				1,078,449
b	Total plan liabilities	7b		<u> </u>		-		
С	Net plan assets (subtract line 7b from line 7a)	7c	1,	003,	352			1,078,449
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun					(b) Total
а	Contributions received or receivable from:							(b) rotal
	(1) Employers	8a(1)		4,	224			
	(2) Participants	8a(2)		14,	333			
-	(3) Others (including rollovers)	8a(3)						
	Other income (loss)	8b		73,	382			
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		2				91,939
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		W	226			
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	8e					44	
f	Administrative service providers (salaries, fees, commissions)	8f				*		
<u>g</u>	Other expenses	8g		16,	616			
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	#-					16,842
i	Net income (loss) (subtract line 8h from line 8c)	8i						75,097
j	Transfers to (from) the plan (see instructions)	8j				Q.	137	
Pai	t IV Plan Characteristics							
9a	If the plan provides pension benefits, enter the applicable pension	feature code	es from the List of Pla	an Cha	racteri	stic Co	odes in t	the instructions:
b	2E 2J 2K 3D  If the plan provides welfare benefits, enter the applicable welfare fe	eature codes	from the List of Plai	n Chara	acterist	ic Cod	des in th	e instructions:
Par			·					
10	During the plan year:				Yes	No	N/A	Amount
а	Was there a failure to transmit to the plan any participant contributescribed in 29 CFR 2510.3-102? (See instructions and DOL's Verogram)	oluntary Fid	uciary Correction	10a		х		
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not inc	clude transactions	10b		х		
С	Was the plan covered by a fidelity bond?			10c	Х			120,000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	fidelity bond	, that was caused	10d		х		
е	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.)	er persons be or all of the	by an insurance benefits under	10e		х		
f	Has the plan failed to provide any benefit when due under the plan	THE RESERVE THE PERSON NAMED IN		10f		Х		
g	Did the plan have any participant loans? (If "Yes," enter amount as	of year-end	1.)	10g		Х		
h	2520.101-3.)			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 n	otice or one of the	10i				

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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	nedule S	В		'es 🗌 No
_11a	The state of the s		11a			
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the CERISA?	Code or section	n 302 o	f	\ \	es X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)					
a	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see ingranting the waiver.	structions, an Month	d enter i Dav		of the lette Year	r ruling
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)						
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?			Yes	X N	)
	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 broughout 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.)	tify the plan(s	) to			
1	3c(1) Name of plan(s):	13c(2)	EIN(s)		13c(3)	PN(s)
Part	VIII Trust Information					
14a i	Name of trust		14b 1	Γrust's Ε	IN	
14c	Name of trustee or custodian				or custodia e number	an's
Part	IX IRS Compliance Questions					
15a	ls the plan a 401(k) plan? If "No," skip b	Yes			No	***************************************
	How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:	☐ safe h	ent year'	L	"Prior yea test	ar" ADP
	What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:	Ratio	entage		erage nefit test	□ N/A
	Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?	Yes			] No	
1/a	If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS the letter and the serial number	opinion letter	or advis	sory lette	er, enter the	date of
17b	If the plan is an individually-designed plan that received a favorable determination letter from the IRS, eletter	nter the date	of the m	ost rece	nt determin	ation
24	Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not sepa service?	arated from	Yes		No	
	Was any plan participant a 5% owner who had attained at least age 70 ½ during the prior plan year?		Yes		No	