Form 5500-SF Short Form Annual Return/Report of Small Emperaturent of the Treasury Benefit Plan					of Small Empl	oyee	OMB Nos. 1210-0110 1210-0089				
Internal Revenue Service This form is required to be filed under sections 104 and 4065 of the Employee							2018				
Employee Be	epartment of Labor enefits Security Administration	– Income Security Act of 1974		e Code (the Code)		Internal	This Form is Open to Public Inspection				
	enefit Guaranty Corporation	Complete all entries in a		ce with the instru	uctions to the Form 5	500-SF.					
Part I	Part I Annual Report Identification Information For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018										
For calenda											
A This ret	urn/report is for:	X a single-employer plan	list c				vith the form instructions.)				
B This retu	urn/report is	a one-participant plan		-							
		the first return/report	the final return/report a short plan year return/report (less than 12 months)								
•		an amended return/report	a sho	ort plan year return	/report (less than 12 m	onths)					
C Check	box if filing under:	Form 5558		matic extension		DFVC p	rogram				
		special extension (enter descri									
Part II		rmation—enter all requested inf	formation			41					
1a Name CENTRAL W		DISORDER CENTER, PC 401K P	PLAN			•	number				
						(PN)	tive date of plan				
							01/01/2005				
		yer, if for a single-employer plan) m, apt., suite no. and street, or P.O	D. Box)			2b Employer Identification Number (EIN) 91-1682421					
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 number					
						509-452-5378 2d Business code (see instructions)					
	SITY PARKWAY					621111					
SUITE 103 YAKIMA, WA	A 98901										
3a Plan a	dministrator's name ar	nd address Same as Plan Spon	nsor.			3b Adm	inistrator's EIN				
CENTRAL W	ASHINGTON SLEEP	DISORDERS CLINIC 111 UNIVI SUITE 103		PARKWAY		3c Adm	91-1682421 inistrator's telephone number				
		YAKIMA, V	WA 9890 ⁻	1			509-452-5378				
		e plan sponsor or the plan name ha				4b EIN					
•	an, enter the plan spo or's name	nsor's name, EIN, the plan name a	and the pla	an number from th	e last return/report.	4d PN	 ?N				
C Plan N						-					
5a Totalı	number of participants	at the beginning of the plan year				5a	3				
		at the end of the plan year				5b	3				
		account balances as of the end of t			•	5c	3				
d(1) Tota	al number of active pa	rticipants at the beginning of the pla	lan year			5d(1)	2				
• • •	d(2) Total number of active participants at the end of the plan year										
than	100% vested	terminated employment during the				5e	0				
		or incomplete filing of this return									
SB or Sche	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.										
SIGN		/valid electronic signature.	05	5/30/2019	GEOFFREY GREENE	BERG					
HERE	Signature of plan a	dministrator	C	Date	Enter name of individ	ual signing	as plan administrator				
SIGN											
HERE	Signature of emplo	yer/plan sponsor		Date	Enter name of individ	ual signing	as employer or plan sponsor				

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6a	Were all of the plan's assets during the plan year invested in eligib	le assets?	(See instructions.)				X Yes	No
b	b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)							
	If you answered "No" to either line 6a or line 6b, the plan cann		,					
c	If the plan is a defined benefit plan, is it covered under the PBGC in							rmined
Ŭ	If "Yes" is checked, enter the My PAA confirmation number from the							
		01 D00 pi	ernan ming for the p	an you			(000 mono	etternet.)
Pa	rt III Financial Information							
7	Plan Assets and Liabilities		(a) Beginning o	of Year			(b) End of Year	
а	Total plan assets	7a	124	47861			1150072	
b	Total plan liabilities	7b		183				
C	Net plan assets (subtract line 7b from line 7a)	7c	124	47678			1150072	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) Total	
а	Contributions received or receivable from: (1) Employers	8a(1)		3472				
	(2) Participants	8a(2)						
	(3) Others (including rollovers)	8a(3)						
b	Other income (loss)	8b	-6	60980				
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					-57508	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	2	20000				
е	Certain deemed and/or corrective distributions (see instructions)	8e						
f	Administrative service providers (salaries, fees, commissions)	8f						
g	Other expenses	8g	2	20098				
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					40098	
i	Net income (loss) (subtract line 8h from line 8c)	8i					-97606	
j	Transfers to (from) the plan (see instructions)	8j						
Pa	t IV Plan Characteristics							
9a	If the plan provides pension benefits, enter the applicable pension $2E$ 2J 2K 3D	feature co	des from the List of Pla	an Char	acteris	stic Co	des in the instructions:	
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature code	es from the List of Plar	n Chara	cterist	ic Cod	es in the instructions:	
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 Fi	iduciary Correction	10a		x		
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not i	nclude transactions	10u		Х		
С				10c	Х		1200	000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		x		
e	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.).	e or all of t	the benefits under	10e		x		
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		Х		
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-e	nd.)	10g		Х		
h	If this is an individual account plan, was there a blackout period?	(See instru	ctions and 29 CFR					

10h

10i

X

2520.101-3.)

If 10h was answered "Yes," check the box if you either provided the required notice or one of the

exceptions to providing the notice applied under 29 CFR 2520.101-3

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Part	VI	Pension Funding Compliance						
11		nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and rm 5500) and line 11a below)			B		Yes	No
11a	Ent	er the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		11a				
12	ERI	his a defined contribution plan subject to the minimum funding requirements of section 412 of the C SA? "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)		n 302 o	f 	[Yes	X No
а		waiver of the minimum funding standard for a prior year is being amortized in this plan year, see institution the waiver.		l enter _ Da		e of the le		ing
lf	you d	completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line	13.		-			
b	Ente	r the minimum required contribution for this plan year		12b				
С	Ente	r the amount contributed by the employer to the plan for this plan year		12c				
d		tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the ative 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?			Ye	s X	No	
	lf "Y	es," enter the amount of any plan assets that reverted to the employer this year		13a				
b		re all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brou trol of the PBGC?	ght under the			Yes	× N	0
С		luring this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident ch assets or liabilities were transferred. (See instructions.)	tify the plan(s)	to				
1	3c(1) Name of plan(s):	13c(2)	EIN(s)		130	:(3) PN	l(s)

Form 5500-SF	Short Form Annual	Return/Report	t of Small Emplo	VAA	OMB Nos. 1210-0110			
Department of the Treasury		Benefit Plan		ycc	1210-0089			
Internal Revenue Service	This form is required to be filed u Income Security Act of 1974 (El				2018			
Department of Labor Employee Benefits Security Administration		evenue Code (the Cod		itemai	This Form is Open to			
Pension Benefit Guaranty Corporation	▶ Complete all entries in acc	cordance with the inst	ructions to the Form 550	0-SF.	Public Inspection			
	Identification Information							
For calendar plan year 2018 or f		1/01/2018	and ending		1/2018			
A This return/report is for:		list of participating er	lan (not multiemployer) (Fi mployer information in acc		-			
B This return/report is	a one-participant plan	a foreign plan						
	the first return/report	the final return/report						
	an amended return/report] a short plan year retu	rn/report (less than 12 mor	nths)				
C Check box if filing under:	Form 5558	automatic extension	Г	DFVC pr	rogram			
	special extension (enter descripti	-	L]				
Part II Basic Plan Info	Drmation—enter all requested inform	mation						
1a Name of plan				1b Three	e-digit			
CENTRAL WASHINGTO	ON SLEEP DISORDER CENTE	R, PC 401K PL	AN		number			
				(PN)				
					tive date of plan 01/2005			
2a Plan sponsor's name (emplo	oyer, if for a single-employer plan)				oyer Identification Number			
	Mailing address (include room, apt., suite no. and street, or P.O. Box)				(EIN) 91-1682421			
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 number 509-452-5378				
111 UNIVERSITY PA	ARKWAY			2d Busin	ess code (see instructions)			
SUITE 103								
YAKIMA	WA 98901			621	111			
	nd address 🗌 Same as Plan Sponso				nistrator's EIN			
CENTRAL WASHINGTO	ON SLEEP DISORDERS CLIN	IIC			1682421 nistrator's telephone number			
111 UNIVERSITY PA	ARKWAY				nistrator s telephone number			
SUITE 103								
YAKIMA	WA 98901			509	-452-5378			
4 If the name and/or EIN of th	e plan sponsor or the plan name has o	changed since the last i	return/report filed for	4b EIN				
	onsor's name, EIN, the plan name and	the plan number from t		Ad DU				
 a Sponsor's name c Plan Name 				4d PN				
• Flat Halle								
5a Total number of participants	s at the beginning of the plan year			5a	3			
	s at the end of the plan year			5b	3			
c Number of participants with	account balances as of the end of the	plan year (only defined	1 contribution plans	5c	-			
					3			
	articipants at the beginning of the plan	•		5d(1)	2			
	articipants at the end of the plan year			5d(2)	2			
	o terminated employment during the pla			5e	0			
Caution: A penalty for the late	or incomplete filing of this return/re	port will be assessed	l unless reasonable caus					
Under penalties of perjury and ot SB or Schedule MB completed a belief, it is true, conject, and com	ther penalties set forth in the instruction me signed by an enrolled actuary, as w	ns, I declare that I have vell as the electronic ve	e examined this return/report, rsion of this return/report,	ort, includir and to the	ng, if applicable, a Schedule best of my knowledge and			
SIGN AAN	dia	5/23/19	GEOFFREY GREENI	BERG	· · · · · · · · · · · · · · · · · · ·			
HERE Signature of plan a	administrator	Date	Enter name of individua		e nlan administrator			
SIGN				ai siyiiiny a	as plan aunimistrator			
HERE					· · · · · · · · · · · · · · · · · · ·			
For Paperwork Reduction Act Notic	oyer/plan sponsor ce, see the Instructions for Form 5500-SF	Date	Enter name of individua	ai signing a	as employer or plan sponsor Form 5500-SF (2018)			

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	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	X Yes No
b	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)	X Yes 🗌 No
	If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.	
c	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	Not determined
	If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year	. (See instructions.)

7	Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
а	Total plan assets	7a	1,247,861	1,150,072
b	Total plan liabilities	7b	183	
c	Net plan assets (subtract line 7b from line 7a)	7c	1,247,678	1,150,072
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a	Contributions received or receivable from: (1) Employers	8a(1)	3,472	
	(2) Participants	8a(2)		
	(3) Others (including rollovers)	8a(3)		
b	Other income (loss)	8b	-60,980	
<u> </u>	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		-57,508
d 	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	20,000	
e	Certain deemed and/or corrective distributions (see instructions)	8e		
f	Administrative service providers (salaries, fees, commissions)	8f		
<u> </u>	Other expenses	8g	20,098	
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		40,098
<u> i </u>	Net income (loss) (subtract line 8h from line 8c)	8i		-97,606
j	Transfers to (from) the plan (see instructions)	8j		
Pa	rt IV Plan Characteristics	6		
9a	If the plan provides pension benefits, enter the applicable pension $2E$ 2J 2K 3D	feature co	des from the List of Plan Characteristic	Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10	During the plan year:		Yes	No	Amount
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		x	
b				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 fidelity bond, that was caused 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.)	10e		x	
f	Has the plan failed to provide any benefit when due under the plan?	10f		Х	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		Х	
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		х	
I	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

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Part	VI Pension Funding Compliance									
11	В									
11a	11a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 11a									
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?										
	(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 ir granting the waiver.		d enter I Day		of the letter ruling Year					
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							
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 left of a negative amount)										
e 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?			Ye	X No					
	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 bro- control of the PBGC?				Yes X No					
с	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.									
13c(1) Name of plan(s): 13c(2)			EIN(s)		13c(3) PN(s)					
Antoria and a fair and a fair and a fair			1944-049-049-049-049-049-049-049-049-049-							
Automational Contractor										