## Form 5500-SF

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

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

2018

This Form is Open to **Public Inspection** 

A This return/report is or:    a single-employer plan   a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)   a non-e-participant plan   a toreign   a toreign plan   a toreign plan   a toreign   a toreign plan			dentification information									
A This return/report is for:    a one-participant plan   a foreign plan   be final return/report   the final return/report   an amended return/report   an amended return/report   an amended return/report   as short plan year return/report (less than 12 months)    C C Check box if filing under:   Form \$558   automatic extension   DFVC program	For calendar plar	n year 2018 or fisca	al plan year beginning 01/01/2	2018		and ending 12	2/31/2	018				
B This return/report is	M a single citiple of plan							-				
In the Institution of Part (Part III)   Institution of Part III   In			a one-participant plan			, ,,	occidance with the form metidetione.					
C Check box if filing under:	B This return/report is the first return/report the final return/report											
Part II   Basic Plan Information—enter all requested information   Ta Name of plan   To Three-digit plan number (PN)   Dot			an amended return/report	a s	hort plan year return	/report (less than 12 m	onths	)				
Part II   Basic Plan Information—enter all requested information   1a Name of plan   1a Name of plan   1c Effective date of plan   1c Effect	C Check box if t	filing under:	Form 5558	au	tomatic extension		DF	FVC program				
18			special extension (enter desc	ription)								
18	Part II Bas	sic Plan Inforr	nation—enter all requested in	nformatio	on							
Plan number (PN)   001   C Effective date of plan (O10/12/008)   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) (City or fown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)   CENTRAL VALLEY GLASS, INC.   2b Employer Identification Number (EIN) 91-1444/058   2c Sponsor's telephone number 509-968-6509   2d Business code (see instructions)   238 I/O   238 I/O   238 I/O   238 I/O   24 Employer Identification Number (EIN) 91-1444/058   2c Sponsor's telephone number 509-968-6509   2d Business code (see instructions)   238 I/O   24 Employer Identification Number (IN) 91-1444/058   2d Business code (see instructions)   238 I/O   25 Employer Identification Number (IN) 91-1444/058   2d Business code (see instructions)   238 I/O   24 Employer Identification Number (IN) 91-1444/058   2d Business code (see instructions)   238 I/O   24 Employer Identification Number 509-968-6509   2d Business code (see instructions)   238 I/O   24 Employer Identification Number 509-968-6509   2d Business code (see instructions)   238 I/O   24 Employer Identification Number 509-968-6509   2d Business code (see instructions)   238 I/O   24 Employer Identification Number 609-968-6509   2d Business code (see instructions)   238 I/O   24 Employer Identification Number 609-968-6509   24 Employer Identification Number 609-968-6509   2d Business code (see instructions)   24 Employer Identification Number 609-968-6509   24 Employer Identification Number 609-968-6509   2d Business code (see instructions)   24 Employer Identification Number 609-968-6509   2d Business code (see instructions)   24 Employer Identification Number 609-968-6509   2d Business code (see instructions)   2d Employer Identification Number 609-968-6509							1b	Three-digit				
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) City or town, state or province, country, and 2IP or foreign postal code (if foreign, see instructions)  2b Employer Identification Number (EIN) 91-1444058  2c Sponsor's telephone number 509-969-8909  2d Business code (see instructions)  3d W. MEAD AVE YAKIMA, WA 98902  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's telephone number 509-969-8909  2d Business code (see instructions) 23b Administrator's telephone number 509-969-8909  2d Business code (see instructions) 23b Administrator's telephone number 609-969-96909  2d Business code (see instructions) 2d Business code	•		1(K) PLAN				.~	plan number	001			
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)							1c	` '	f plan			
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26 Sponsor's telephone number 569-69-6909 2d Business code (see instructions) 238 Inc.  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number description of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  a Sponsor's name c Plan Name  5a 12  b Total number of participants at the beginning of the plan year 5b 11  c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  d(1) Total number of active participants at the beginning of the plan year with accrued benefits that were less than 100% vested.  d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.  Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Signature of plan administrator  Date Enter name of individual signing as plan administrator	Mailing addr	ess (include room,	apt., suite no. and street, or P.C									
2d Business code (see instructions) 30 W. MEAD AVE YAKIMA, WA 98902  3a Plan administrator's name and address  Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number  4 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, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name  5a Total number of participants at the beginning of the plan year. 5 Total number of participants at the end of the plan year. 5 Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  4d PN  c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  4d(2) Total number of active participants at the beginning of the plan year with accrued benefits that were less than 10% wested.  5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 10% wested.  6a Unifore penalistic of perity and other penalistics set forth in the instructions, I declare that I have examined the return/report, and to the best of my knowledge and belief, it is true, correct, and complete.  Sign Filed with authorized/valid electronic signature.  07/08/2019 TERRI JACKSON  Filed with authorized/valid electronic signature.  07/08/2019 TERRI JACKSON	City or town,	state or province,	country, and ZIP or foreign post	tal code	(if foreign, see instru	uctions)	20	Spannar'a talan	hana numbar			
3a Plan administrator's name and address ⊠ Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number  4 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, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name  5a Total number of participants at the beginning of the plan year. 5 It Total number of participants at the end of the plan year. 5 It Total number of participants at the end of the plan year. 5 It Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	CENTRAL VALLEY	Y GLASS, INC.					·					
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SIGN HERE     Filed with authorized/valid electronic signature.     07/08/2019     TERRI JACKSON       Signature of plan administrator     Date     Enter name of individual signing as plan administrator       SIGN HERE     HERE	SB or Schedule I	MB completed and	signed by an enrolled actuary, a									
Signature of plan administrator  Date  Enter name of individual signing as plan administrator  SIGN HERE					07/08/2019	TERRI JACKSON	RIJACKSON					
HERE	HERE Sign	nature of plan adr	ministrator		Date	Enter name of individ	ual siç	gning as plan adr	ministrator			
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor												
	HERE Sign	nature of employe	er/plan sponsor		Date	Enter name of individ	Enter name of individual signing as employer or plan sponsor					

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b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IOPA)  If you answered "No" to either line 8 or line 8s, the plan cannot use Form 5500-SF and must instead use Form 5500.  If you answered "No" to either line 8 or line 8s, the plan cannot use Form 5500-SF and must instead use Form 5500.  If you answered "No" to either line 8 or line 8s, the plan cannot use Form 5500-SF and must instead use Form 5500.  If you answered "No" to either line 8 or line 8s, the plan cannot use Form 5500-SF and must instead use Form 5500.  If you answered "No" to either line 8 or line 8s, the plan year.  If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year.  Part III Financial Information  The plan steads and Liabilities  (a) Beginning of Year  (b) End of Year  The plan steads and Liabilities  (b) End of Year  The plan steads and Liabilities  The plan stead of the PBGC premium filing for this plan year  The plan steads and the plan steads and the plan year  The plan steads and the plan steads and the plan year and the plan year.  The plan steads (author the plan year and the plan year and the plan steads (author the plan year)  The plan steads (author the plan steads the plan year)  The plan steads (author the plan steads the plan steads the plan steads (author the plan stead		Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)						X Y	es No	
If you answerd "No" to either line 6 aor line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.  If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	b								XY	es $\Pi$ No
Part III   Financial Information   Financial Information		· · · · · · · · · · · · · · · · · · ·							🗀	Ц
Part III Financial Information 7 Plan Assets and Liabilities	С	If the plan is a defined benefit plan, is it covered under the PBGC in	nsurance p	orogram (see ERISA se	ection 4	021)?		Yes No	Not d	etermined
7   Plan Assets and Liabilities		If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC p	remium filing for this p	lan yea	r			(See ins	tructions.)
a Total plan assets	Pa	rt III   Financial Information								
a Total plan assets	7	Plan Assets and Liabilities		(a) Beginning (	of Year			(b) Er	d of Year	
C Net plan assets (subtract line 7b from line 7a)	а	Total plan assets	7a	` '				` _		1
8 Income, Expenses, and Transfers for this Plan Year a Contributions received or receivable from: (1) Employers (2) Participants. (3) Others (including rollovers). (3) Others (including rollovers). (4) Employers (5) Other income (loss). (6) Other income (loss). (7) Other income (loss). (8) Other income (loss). (8) Other income (loss). (8) Other income (loss). (8) Other spatial (including direct rollovers and insurance premiums to provide benefits). (8) Other spatial (including direct rollovers and insurance premiums to provide benefits). (8) Other spatial (including direct rollovers and insurance premiums to provide benefits). (8) Other spatial (including direct rollovers and insurance premiums to provide benefits). (8) Other spatial (including direct rollovers). (9) Other spatial (including direct rollovers). (10) Other spatial (including direct rollovers). (11) Other including direct rollovers). (12) Other spatial (including direct rollovers). (13) Other spatial (including direct rollovers). (14) Other including direct rollovers). (15) Other spatial (including direct rollovers). (16) Other spatial (including direct rollovers). (17) Other spatial (including direct rollovers). (18) Other spatial (including direct rollovers). (18) Other spatial (including direct rollovers). (19) Other spatial (including direct rollovers). (19) Other spatial (including direct rollovers). (10) Other spatial (including direct rollovers). (11) Other spatial (incl	b		7b							
a Contributions received or receivable from: (i) Employers	С	Net plan assets (subtract line 7b from line 7a)	7c	123	25715				119676	1
(2) Participants	8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	ıt			(b)	Total	
(2) Partioipants	а				44000					
(3) Others (including rollovers)			` '							
b Other income (loss)					89095					
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)					77202					
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)		` /		-	11293				0040	4
e Certain deemed and/or corrective distributions (see instructions) 8e f Administrative service providers (salaries, fees, commissions) 8f f Administrative service providers (salaries, fees, commissions) 8f f Administrative service providers (salaries, fees, commissions) 8f g Other expenses			80						2313	4
f Administrative service providers (salaries, fees, commissions)		. , .	8d	;	39629					
g Other expenses	е	Certain deemed and/or corrective distributions (see instructions)	8e							
h Total expenses (add lines 8d, 8e, 8f, and 8g)	f	Administrative service providers (salaries, fees, commissions)	8f	,	12459					
i Net income (loss) (subtract line 8h from line 8c)	g	Other expenses	8g							
Transfers to (from) the plan (see instructions)	h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						5208	8
Part IV Plan Characteristics  9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  2E 2F 2G 2J 2K 2T 3D  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:  a 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)  b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)  C Was the plan covered by a fidelity bond?  d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?  e 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  10e X  10e X  11of X  9 Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)  11of X  12 If 10h was answered "Yes," check the box if you either provided the required notice or one of the	<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						-2895	4
If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:    Example   Examp	j	Transfers to (from) the plan (see instructions)	8j							
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	Pa	rt IV Plan Characteristics								
Part V   Compliance Questions	9a		feature co	odes from the List of Plant	an Cha	racteri	stic Co	odes in the ir	structions:	
10 During the plan year:  a 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)	b		eature cod	les from the List of Pla	n Chara	acteris	tic Cod	des in the ins	structions:	
10 During the plan year:  a 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)										
a 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)	Par	t V   Compliance Questions				Ti-				
described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)		<u> </u>				Yes	No		Amount	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	a	described in 29 CFR 2510.3-102? (See instructions and DOL's V	oluntary F	iduciary Correction	10a		X			
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?  e 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.)  f Has the plan failed to provide any benefit when due under the plan?  g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)  h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)  10h  X  If 10h was answered "Yes," check the box if you either provided the required notice or one of the	b	<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions			10b		Х			
by fraud or dishonesty?	С	Was the plan covered by a fidelity bond?			10c	X			15	50000
carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	C	·	-		10d		X			
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	е	e 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			10e		X			
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) 10h X  i If 10h was answered "Yes," check the box if you either provided the required notice or one of the	f	<b>f</b> Has the plan failed to provide any benefit when due under the plan?			10f		X		_	_
2520.101-3.)	9	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)					X			
	h	· · · · · · · · · · · · · · · · · · ·	•		10h		X			
	i				10i					

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Part	VI Pension Funding Compliance			
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete (Form 5500) and line 11a below)			Yes No
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 se ERISA?		f	Yes X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)			
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, granting the waiver	and enter Da		of the letter ruling Year
lf y	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?		Yes	s 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 brought under control of the PBGC?	he		Yes X No
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan which assets or liabilities were transferred. (See instructions.)	n(s) to		
1	<b>3c(1)</b> Name of plan(s):	(2) EIN(s)		<b>13c(3)</b> PN(s)