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

Part I	Annual Repor	t Identification Information						
For calenda	ar plan year 2018 or	fiscal plan year beginning 01/01/2	2018	and ending 1	2/31/2018			
A This ret	A This return/report is for: 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 one-participant plan	a foreign plan					
B This retu	urn/report is	the first return/report	the final return/repo	ort				
		an amended return/report	a short plan year re	eturn/report (less than 12 m	onths)			
C Check b	oox if filing under:	X Form 5558	automatic extension	on	DFVC progra	am		
		special extension (enter descr	ription)					
Part II	Basic Plan Inf	ormation—enter all requested in	formation					
1a Name CASCADE C	•	LATION, LLC 401(K) RETIREMENT	SAVINGS PLAN		1b Three-dig plan num (PN) ▶	•		
					1c Effective	date of plan 01/01/2008		
		loyer, if for a single-employer plan)			2b Employer	Identification Number		
		om, apt., suite no. and street, or P.C nce, country, and ZIP or foreign post		nstructions)	(EIN)	13-4295977		
CASCADE C	OMMERCIAL INSUI	LATION, LLC			2c Sponsor's telephone number 425-823-8427			
					2d Business code (see instructions)			
12536 - 130T KIRKLAND, \						238300		
3a Plan a	dministrator's name a	and address X Same as Plan Spor	nsor.		3b Administr	ator's EIN		
					3c Administr	ator's telephone number		
		he plan sponsor or the plan name ha			4b EIN			
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 4d PN								
C Plan N	lame							
5a Total r	number of participant	ts at the heginning of the plan year			5a	10		
5a Total number of participants at the beginning of the plan yearb Total number of participants at the end of the plan year			5b	9				
C. Number of participants with account belances as of the and of the plan year (only defined contribution plans					9			
	,	participants at the beginning of the pl			5d(1)	8		
d(2) Total number of active participants at the end of the plan year				5d(2)	7			
		o terminated employment during the			5e	1		
Caution: A	penalty for the late	or incomplete filing of this return	n/report will be assess	sed unless reasonable ca	use is establish	ied.		
SB or Sche		other penalties set forth in the instruction and signed by an enrolled actuary, a supplete.						
SIGN		d/valid electronic signature.	08/13/2019	MARTY BRUNER	RTY BRUNER			
HERE	Signature of plan	administrator	Date	Enter name of individ	ual signing as pl	an administrator		
SIGN	Filed with authorize	d/valid electronic signature.	08/13/2019	MARTY BRUNER	MARTY BRUNER			
HERE	Signature of empl	lover/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor				

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Fart III Financial Information Financial Information	t determined instructions.)					
7 Plan Assets and Liabilities (a) Beginning of Year (b) End of Ye a Total plan assets						
a Total plan assets						
b Total plan liabilities	695					
C Net plan assets (subtract line 7b from line 7a)						
8 income, Expenses, and Transfers for this Plan Year a Contributions received or receivable from: (1) Employers	0					
a Contributions received or receivable from: (1) Employers	838695					
(1) Employers						
(3) Other including rollovers)						
b Other income (loss)						
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)						
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)						
to provide benefits)	138					
f Administrative service providers (salaries, fees, commissions)						
g Other expenses						
h Total expenses (add lines 8d, 8e, 8f, and 8g)						
i Net income (loss) (subtract line 8h from line 8c)						
j Transfers to (from) the plan (see instructions)	5743					
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 instruction 2A 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 instruction 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)	605					
9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instruction 2A						
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instruction 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						
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						
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	:					
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)						
described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	ıt					
i i i i i i i i i i i i i i i i i i i						
1960.000 011 110 1000/						
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?	500000					
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.)	500000					
f Has the plan failed to provide any benefit when due under the plan?	500000 7185					
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.)						
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						

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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 section 302 of ERISA?				
	(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		
C Enter the amount contributed by the employer to the plan for this plan year				
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	e Will the minimum funding amount reported on line 12d be met by the funding deadline?			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	b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			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	3c(1) Name of plan(s):	(2) EIN(s)		13c(3) PN(s)

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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OMB Nos. 1210-0110 1210-0089

2018

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A This return/report is for:	Part I		t Identification Informatio					
A This return/report is or an one-participant plan is of participants employer information in accordance with the form instructions.) B This return/report is in first return/report in the first return/report in an amended return/report in a short plan year return/report (less than 12 months) C Check box if filling under: S Form 5558 in automatic extension in DFVC program Part II Sasic Plan Information—enter all requested information 1a Name of plan CASCADE COMMERCIAI, INSULATION, ILC 401 (K) RETIREMENT SAVINGS PLAN 2a Plan sponsor's name (employer, if for a single-employer plan) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite no. and street, or P.O. Box) Malling address (include room, apt., suite room,	For calend	dar plan year 2018 or	fiscal plan year beginning	01/01/2018	and ending	12/31	./2018	
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C Check box if filling under: S Form 5558 automatic extension DFVC program Part II Basic Plan Information—enter all requested information 1a Name of plan CASCADE COMMERCIAL INSULATION, LLC 401 (K) (PN) 001 CETTREMENT SAVINGS PLAN 1c Effective date of plan number Mailing address (include room, apt., sulle no. and street, or P.O. Box) CRASCADE COMMERCIAL INSULATION, LLC 401 (K) (PN) 001 CASCADE COMMERCIAL INSULATION, LLC 401 (K) (PN) 001 CETTREMENT SAVINGS PLAN 1c Effective date of plan number Mailing address (include room, apt., sulle no. and street, or P.O. Box) CRASCADE COMMERCIAL INSULATION, LLC 401 (K) (PN) 201 CASCADE CASCA	D This ret	turn/report is	the first return/report	the final return/report	;			
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Mailing address (include room, apt, suite no, and Street, or P.O. Box) CRSCADE COMMERCIAL INSULATION, LLC 20 Sponsor's telephone number (425) 823-8427 21 Business code (see instructions) 12536 - 130TH LN NE KIRKLAND 30 Plan administrator's name and address Same as Plan Sponsor. 31 Administrator's name and address Same as Plan Sponsor. 32 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. 4 Sponsor's name C Plan Name 4 If the name and/or EIN of the plan sponsor or the plan name and the plan number from the last return/report. 4 Sponsor's name C Plan Name 5 Total number of participants at the beginning of the plan year. 5 D Total number of participants at the end of the plan year. 5 D Total number of participants at the end of the plan year. 5 D Total number of participants at the beginning of the plan year (only defined contribution plans complete this item). 6 (1) Total number of active participants at the beginning of the plan year. 6 D Number of participants with account balances as of the end of the plan year. 6 D Number of participants with account balances as of the end of the plan year. 6 D Number of participants with account balances as of the end of the plan year. 6 D Number of participants with account balances as of the end of the plan year. 6 D Number of participants with account balances as of the end of the plan year. 6 D Number of participants with account balances as of the end of the plan year. 6 Number of participants with account balances as of the end of the plan year. 6 Number of participants with account balances as of the end of the plan year. 7 D Number of participants with account balances as of the end of the plan year. 8 Number of participants with account balances as of the end of the plan year. 9 Number of participants who terminated employment during the pla	KEIIKE	MENI SAVINGS	FLAN					
CASCADE COMMERCIAL INSULATION, LLC CASCADE COMMERCIAL INSULATION, LLC 2c Sponsor's telephone number (425) 823-8427 2d Business code (see instructions) 12536 - 130TH LN NE KIRKLAND WA 98034 238300 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's EIN 4d 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 c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 5c go d(1) Total number of active participants at the beginning of the plan year d(2) Total number of cative participants at the beginning of the plan year somplete this item). 5c go d(1) Total number of cative participants at the beginning of the plan year somplete this item). 6d(2) Total number of cative participants at the beginning of the plan year somplete this item). 6d(1) Total number of cative participants at the beginning of the plan year somplete this item). 6d(2) Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 6d(2) Total number of cative participants at the beginning of the plan year 5d(1) 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	2a Plan s	sponsor's name (empl	loyer, if for a single-employer plan))		2b Employe	r Identification Number	
12536 - 130TH LN NE	iviaiiin Citv o	ig address (include roc r town, state or provin	om, apt., suite no, and street, or P ice, country, and ZIP or foreign po	.O. Box) istal code (if foreign, see ins	structions)			
A	CASCADE COMMERCIAL INSULATION, LLC			i dodona)	2c Sponsor's telephone number (425) 823-8427			
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d(2) Total number of active participants at the end of the plan year				5d(1)	. 8			
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 filing of this return/report will be assessed unless reasonable cause is established. 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 HERE Signature of plan administrator Date Enter name of individual signing as plan administrator MARTY BRUNER Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested			5e 1				
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SIGN HERE Signature of employer/plan sponsor Date MARTY BRUNER MARTY BRUNER Enter name of individual signing as employer or plan sponsor	HERE	Signature of plan a	administrator	Date	Enter name of individ	lual signing as plan administrator		
Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor			30.00					
			The state of the s		Enter name of individ	nter name of individual signing as employer or plan sponsor		