#### 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

2018

This Form is Open to **Public Inspection** 

Parti	Annual Repor	t identification information							
For calend	dar plan year 2018 or	fiscal plan year beginning 01/01/2	2018	and ending 12	/31/2018				
A This re	<b>A</b> 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 return/report is the first return/report the final return/report									
		rn/report (less than 12 mo	onths)						
C Check	box if filing under:	X Form 5558	automatic extension		DFVC program	m			
		special extension (enter desc	ription)						
Part II	Basic Plan Inf	ormation—enter all requested in	formation						
1a Name	of plan	·			1b Three-digi	t			
	OSPACE RETIREMEI	NT PLAN			plan numb	er			
					(PN) <b>•</b>	001			
					1c Effective d	•			
						01/01/2010			
		loyer, if for a single-employer plan) om, apt., suite no. and street, or P.0	) Royl			dentification Number			
		ice, country, and ZIP or foreign posi		tructions)	(EIN)	20-3314490			
-	OSPACE, LLC		, -	,	2c Sponsor's telephone number 206-276-2306				
					2d Business code (see instructions)				
	ER BLVD. S.E., SUIT ME, WA 98065	E 171			541990				
ONOQUALI	ME, WA 30003								
<b>3a</b> Plan s	administrator's name	and address X Same as Plan Spo	neor		<b>3b</b> Administra	tor's FIN			
ou mane		and address A came as i lair ope	11301.						
					3c Administrator's telephone number				
		ne plan sponsor or the plan name honsor's name, EIN, the plan name			<b>4b</b> EIN				
	sor's name	, , ,	•	·	4d PN				
C Plan	Name								
					_				
		s at the beginning of the plan year.			5a	6			
		s at the end of the plan year			5b	6			
		account balances as of the end of		-	5c	6			
<b>d(1)</b> To	tal number of active p	articipants at the beginning of the p	lan year		5d(1)	6			
<b>d(2)</b> To	tal number of active p	articipants at the end of the plan ye	ar		5d(2)	6			
		o terminated employment during the			5e	0			
Caution:	A penalty for the late	or incomplete filing of this retur	n/report will be assessed	l unless reasonable cau					
SB or Sch		other penalties set forth in the instru and signed by an enrolled actuary, a nplete.							
SIGN	Filed with authorize	d/valid electronic signature.	09/25/2019	SAMUEL B. WAGNER					
HERE	Signature of plan	administrator	Date	Enter name of individual signing as plan administrator					
SIGN									
HERE	Signature of employer/plan sponsor Date Enter name of individ					dual signing as employer or plan sponsor			

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	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)					X Yes [	No		
	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.								
С	If the plan is a defined benefit plan, is it covered under the PBGC in							Not determ	
	If "Yes" is checked, enter the My PAA confirmation number from the	ie PBGC p	remium filing for this p	ian yea	r			(See instruct	ions.)
Pa	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning (	of Year			(b) End	of Year	
а	Total plan assets	7a	7:	38541				829382	
b	Total plan liabilities	7b							
С	Net plan assets (subtract line 7b from line 7a)	7c	7:	38541				829382	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t	_		(b) ·	Total	
a	Contributions received or receivable from: (1) Employers	8a(1)	;	31988					
	(2) Participants	8a(2)	(	93317					
	(3) Others (including rollovers)	8a(3)							
b	Other income (loss)	8b	-:	34464					
<u>C</u>	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						90841	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d							
е	Certain deemed and/or corrective distributions (see instructions)	8e							
f	Administrative service providers (salaries, fees, commissions)	8f							
g	Other expenses	8g							
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						0	
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						90841	
j	Transfers to (from) the plan (see instructions)	8j							
Pai	t IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2E 2J 2K 2T 3D	feature co	odes from the List of Plant	an Cha	racteri	stic Co	des in the ins	tructions:	
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Pla	n Chara	acteris	tic Code	es in the insti	ructions:	
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	oluntary F	iduciary Correction			,			
	Program)			10a		X			
	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			83000	)
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	fidelity bo	nd, that was caused	10d		X			
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.)	ne or all of	the benefits under	10e		Х			
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		Х			
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	he require	d notice or one of the	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 Sche (Form 5500) and line 11a below)		В	Y	es 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 ERISA?		:	Y	es 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, and granting the waiver	d enter t Day		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)	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	× N	0
	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?			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(s) which assets or liabilities were transferred. (See instructions.)	to			
1	<b>3c(1)</b> Name of plan(s): 13c(2)	EIN(s)		13c(3)	PN(s)

# Filing Authorization for the 2018 Form 5500-SF

Name of Plan:

WAIV Aerospace Retirement Plan

EIN / PN:

20-3314490/001

Plan Year Ending: December 31, 2018

### Authorization of Practitioner to Electronically Sign and File

I hereby authorize Panagiotu Pension Advisors (PPA) to electronically sign and file the above-named return/report through EFAST2.

I understand that in granting this authority that:

- I must manually sign and date page 1 of the Form 5500-SF and provide an original or scanned copy of that signature page to PPA before the electronic filing can be initiated;
- PPA will retain a copy of this written authorization in its records;
- PPA will notify the individual signing below as plan administrator/employer about any
  inquiries and information it receives from EFAST2, DOL, IRS, or PBGC regarding this
  annual return/report; and
- A copy of my signature, as it appears on page 1 of the Form 5500-SF, will be included
  with the return/report posted by the Department of Labor on the Internet for public
  disclosure.
- PPA shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.

This authorization is applicable only to the filing for the above-named Plan and applies only for Plan year end stated above.

Date: 9.25.2019

Plan Administrator:

Samuel B. Wagner

#### Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

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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 for:    a single-employer plan   a cone-participant plan   a cone-partic	Part   Annual Repo	ort Identification Information						
A This return/report is for:    a one-participant plan   a foreign plan   a foreign plan     B This return/report   the first return/report   the first return/report   the first return/report   a hereign plan   a foreign plan     C Check box if filling under:   Form 5558   subtomatic extension   DEVC program	For calendar plan year 2018 of	r fiscal plan year beginning	01/01/2018	and ending	12/31/20	)1.8		
B This return/report is						Fliers checking this box must attach a cordance with the form instructions.)		
The first return/report   In a manneded return/report   In a hort plan year return/report (less than 12 months)		a one-participant plan	a foreign plan					
C Check box if filling under:  Form 5558  automatic extension  DFVC program  Part II Basic Plan Information—enter all requested information  Ia Name of plan WAIV AEROSPACE RETIREMENT PLAN  Basic Plan Information—enter all requested information  Ia Name of plan WAIV AEROSPACE RETIREMENT PLAN  Ib Three-dight plan number (PN)   001  Ic Effective date of plan 01/01/2010  Ic Effective date of plan on minber of effective date of the plan of effective date of the plan of effective date of effective date of the plan of effective date of the plan of effective date of effecti	B This return/report is							
C Check box if filling under: S Form 5568			<u> </u>	anort (loss than 12 ma	anthe)			
Special extension (enter description)   Part II   Basic Plan Information—enter all requested information   1a Name of plan   WAIV AEROSPACE RETIREMENT PLAN		I all amended return report	☐ a short plan year returning	eport (less triair 12 mc	Altito)			
Part II   Basic Plan Information—enter all requested information	C Check box If filling under:	=		[	DFVC program	1		
18 Name of plan WAIV AEROSPACE RETIREMENT PLAN  29 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) WAIV AEROSPACE, LLC  7829 CENTER BLVD. S.E., SUITE 171  SNOQUALMIE WA 98065  30 Plan administrator's name and address Same as Plan Sponsor.  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  5 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 C Number of participants with account balances as of the end of the plan year (1) Total number of participants with account balances as of the end of the plan year C Plan Name of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants who terminate								
WAIV AEROSPACE RETIREMENT PLAN    Plan sponsor's name (employer, if for a single-employer plan)   1c   Effective date of plan   01/01/2010   2c   Effective date of plan   01/01/2010   2c   Employer destinication Number (ElN) 2 0 - 331.4490   2c   Employer destinication Number (ElN) 2 0 - 331.4490   2c   Sponsor's telephone number   206-276-2306   2d   Business code (see instructions)   2c   Sponsor's telephone number   206-276-2306   2d   Business code (see instructions)   2d   Sponsor's telephone number   206-276-2306   2d   Business code (see instructions)   2d   Sponsor's name and address   Same as Plan Sponsor.   3b   Administrator's telephone number   2d   Administrator's telephone number   2d   PN   2		nformation—enter all requested	information		41			
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, api, sulte no. and street, or P.O. Box) City or fown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) WAIV ABROSPACE, LLC 7829 CENTER BLVD. S.E., SUITE 171 SNOQUALMIE WA 98065 2d Business code (see instructions)  SNOQUALMIE WA 98065 3a Plan administrator's name and address Same as Plan Sponsor.  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. a Sponsor's name C Plan Name  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. a Sponsor's name C Plan Name C Plan Name  5a Total number of participants at the beginning of the plan year C Plan Name  5b Total number of participants at the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C 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 C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the size return/report. b Total number of active participants at the beginning of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the end of the plan year C Number of participants with account balances as of the size return/report will be assessed unless reasonable cause is established. Caustion: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Caustion: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  Caustion: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable c		RETIREMENT PLAN			plan numbe	er		
Mailing address (include room, apt., sulte no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) WAIV AEROSPACE, LLC  7829 CENTER BLVD. S.E., SUITE 171  SNOQUALMIE WA 98065  3a Plan administrator's name and address Same as Plan Sponsor.  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filled for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  Sponsor's name C Plan Name  5a Total number of participants at the beginning of the plan year.  5b Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this flem).  5c (1) Total number of active participants at the beginning of the plan year.  5c (2) Total number of participants with account balances as of the end of the plan year with accrued benefits that were less than 100% wested Caution: A penalty for the late or incomplete filling of this return/report, and to the best of my knowledge and bellef, it is true, correct, page doministrator  Fig. 20 - 2107 Samuel B. Wagner  First name of individual signing as plan administrator  Date Enter name of individual signing as employer or plan sponsor					1c Effective da			
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  WAIV AEROSPACE, LLC  7829 CENTER BLVD. S.E., SUITE 171  SNOQUALMIE WA 98065  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's leiephone number of this plan, enter 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 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 talephone 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 PN  5 Total number of participants at the beginning 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 litem).  6 C Number of participants with account balances as of the plan year.  6 (1) Total number of active participants at the end of the plan year.  6 (2) (3) (4) (4) (5) (5) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	Mailing address (include	room, apt., sulte no. and street, or	P.O. Box)					
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3a Plan administrator's name and address	7829 CENTER BLV	D. S.E., SUITE 171						
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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.  3 Sponsor's name  C Plan Name  5a Total number of participants at the beginning of the plan year								
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Total number of participants at the beginning of the plan year					<b>40</b> CIIV			
5a Total number of participants at the beginning of the plan year	a Sponsor's name				4d PN			
b Total number of participants at the end of the plan year	O I IZII IYAIIIO							
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HERE Signature of plan administrator Date Enter name of Individual signing as plan administrator  SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	SB or Schedule MB complet	ed and signed by an enrolled actua	structions, I declare that I have e ary, as well as the electronic vers	examined this return/re sion of this return/repo	eport, including, if rt, and to the bes	applicable, a Schedule I of my knowledge and		
Signature of plan administrator  SIGN HERE Signature of employer/plan sponsor  Date Enter name of individual signing as plan administrator  Enter name of individual signing as employer or plan sponsor			9.25.2019 Samuel B. Wagner					
SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	HERE Signature of pi	an administrator	Date	Enter name of Individ	dual signing as ni	an administrator		
Signature of employer/plan sponsor  Date  Enter name of individual signing as employer or plan sponsor	SIGN				and the second second			
	Signature of e			Enter name of individ	dual signing as e	mployer or plan sponsor Form 5500-SF (2018)		