Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110 1210-0089

2012

This Form is Open to Public Inspection

Part I	Annual Report Identifi	cation Information				•	
For calendar plan year 2012 or fiscal plan year beginning 06/01/2007 and ending 05/31/2008							
A This return/report is for:							
		x a single-employer plan;	a DFE (s	pecify)			
			П				
B This	eturn/report is:	the first return/report;		return/report;			
		an amended return/report;		lan year return/report (less t		_	
C If the	plan is a collectively-bargained p	lan, check here				> []	
D Check box if filing under:						e DFVC program;	
		special extension (enter des	cription)				
Part		ion—enter all requested informa	ation				1
	e of plan				1b	Three-digit plan number (PN) ▶	501
SCOTC	H PLYWOOD COMPANY, INC.				1c	Effective date of p	I Ian
						12/01/1996	
2a Plan	sponsor's name and address; in	clude room or suite number (emp	oloyer, if for a single-	employer plan)	2b	Employer Identific	ation
SCOTC	H PLYWOOD COMPANY, INC.					Number (EIN) 63-0501795	
300101	1 PLY WOOD COMPANY, INC.				2c	Sponsor's telepho	ne
						number	
РО ВОХ	38	PO BOX 3	38		24	800-936-442	
FULTON	, AL 36446	FULTON,	AL 36446		Zu	Business code (se instructions)	ee
						321210	
Caution	A penalty for the late or incon	nplete filing of this return/repor	t will be assessed	unless reasonable cause i	s establi	shed.	
		alties set forth in the instructions, I					
statemer	its and attachments, as well as the	ne electronic version of this return	n/report, and to the b	est of my knowledge and be	elief, it is t	rue, correct, and cor	nplete.
0.01							
SIGN HERE	Filed with authorized/valid electr	onic signature.	09/03/2013	GLENN TOWNSEND	BLENN TOWNSEND		
	Signature of plan administrat	or	Date	Enter name of individual s	signing as	plan administrator	
SIGN							
SIGN HERE							
	Signature of employer/plan s	ponsor	Date	Enter name of individual s	signing as	employer or plan sp	onsor
SIGN							
HERE							
Signature of DFE Date Enter name of individual signing as DFE Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional) Preparer's telephone number							
	o name (meraamg mm name, me	and dadress, merade .	oom or ound manned		ptional)		

Form 5500 (2012) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor Name	Same as Plan Sponsor Address	3b Administrator's EIN
			3c Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed for this plan, enter the name,	4b EIN
а	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year		5 1251
6	Number of participants as of the end of the plan year (welfare plans complete	te only lines 6a, 6b, 6c, and 6d).	
а	Active participants		. 6a 1251
b	Retired or separated participants receiving benefits		. 6b
С	Other retired or separated participants entitled to future benefits		. 6c
d	Subtotal. Add lines 6a , 6b , and 6c		. 6d 1251
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits	. 6e
f	Total. Add lines 6d and 6e		. 6f 1251
-			
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g
L			
n	Number of participants that terminated employment during the plan year wit less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only	7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List of Plan Characteristics Code	es in the instructions:
b	If the plan provides welfare benefits, enter the applicable welfare feature coo	des from the List of Plan Characteristics Code	s in the instructions:
	4A		
_		Total and the second se	
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that	at apply)
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance (2) Code section 412(e)(3)	insurance contracts
	(3) Trust	(3) Trust	modrance definació
	(4) General assets of the sponsor	(4) General assets of the sp	oonsor
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the number	per attached. (See instructions)
а	Pension Schedules	b General Schedules	
u	(1) R (Retirement Plan Information)		
		(1) H (Financial Inform	,
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	` '	nation – Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) A (Insurance Infor	
	·	(4) X C (Service Provide	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		ng Plan Information)
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction Schedules)

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

Service Provider Information

File as an attachment to Form 5500.

OMB No. 1210-0110

2012

This Form is Open to Public Inspection.

For calendar plan year 2012 or fiscal plan year beginning 06/01/2007	and ending 05/31/2008
A Name of plan SCOTCH PLYWOOD COMPANY, INC.	B Three-digit 501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
SCOTCH PLYWOOD COMPANY, INC.	63-0501795
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information re or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of the compensation on Persons Receiving Only Eligible Indirect Compensation Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of the indirect compensation for which the plan received the required disclosures (see instructions the you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see instructions).	n with services rendered to the plan or the person's position with the the plan received the required disclosures, you are required to this Part. Sion his Part because they received only eligible for definitions and conditions)
received only engine mandet compensation. Complete as many entires as needed (see ms	tructions).
(b) Enter name and EIN or address of person who provided you dis	sclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	sclosure on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	sclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	sclosures on eligible indirect compensation
(2) 2 Sand 2 of dedicate of policies and provided you die	

Schedule C (Form 5500) 2012	Pa	age 2- 1	
(b) Enter name and FIN or a	address of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	address of person who provided yo	ou disclosures on eligible indirect co	mpensation
	<u></u>	-	<u>·</u>
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	u disclosures on eligible indirect cor	mpensation
(h) =			
(D) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation

age 3 -	1		
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
		(a) Enter name and EIN or	address (see instructions)		
BLUE CRC	OSS & BLUE SHIELD	OF ALABAMA		RCHASE PARKWAY EAST HAM, AL 35298		
63-0103830	0					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
23		226414	Yes X No	Yes X No	0	Yes No X
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page	3	-	2
² age	3	-	2

answered	I "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
			,			
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
<u> </u>		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compens	ation, by a service provider, and th	ne service provider is a fiduciary
or provides contract administrator, consulting, custodial, investment advisory, investment mar questions for (a) each source from whom the service provider received \$1,000 or more in indi provider gave you a formula used to determine the indirect compensation instead of an amou many entries as needed to report the required information for each source.	nagement, broker, or recordkeepin irect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	(coo mondono)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

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P	Part II Service Providers Who Fail or Refuse to Provide Information						
4	Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.						
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide				
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide				
_							
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide				
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide				
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				

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Pa	rt III	Termination Information on Accountants and Enrolled Actuaries (see ins	structions)		
а	Name:	(complete as many entries as needed)	b EIN:		
C	Positio		B EIIV.		
d	Addres		e Telephone:		
•	/ ladio		С госраново.		
Ex	olanatio):			
			I		
<u>a</u>	Name:		b EIN:		
d d	Position Address		e Telephone:		
u	Addies	.5.	е тегерпопе.		
Ex	olanatio	n:			
а	Name:		b EIN:		
<u>C</u>	Positio				
d	Addres	SS:	e Telephone:		
Exi	olanatio				
а	Name:		b EIN:		
С	Positio	n:			
d	Addres	ss:	e Telephone:		
Explanation:					
ᄓ	Jianalioi	i.			
а	Name:		b EIN:		
C	Positio				
d	Addres		e Telephone:		
Explanation:					

Form 5500

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

A This return/report is for:

Annual Report Identification Information For calendar plan year 2012 or fiscal plan year beginning 06/01/2007

a multiemployer plan;

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

> Complete all entries in accordance with the instructions to the Form 5500.

and ending

a multiple-employer plan; or

05/31/2008

OMB Nos. 1210-0110 1210-0089

2012

This Form is Open to Public Inspection

		a single-employer plan;	a DFE (s	pecify)			
B This	return/report is:	the first return/report;	☐ the final	return/report;			
	rotalitioportio.	an amended return/report;	느	lan year return/report (le	ss than 12 months)		
C If the	plan is a collectively-bargained r	olan, check here			ŕ		
	ck box if filing under:	Form 5558;		c extension;	the DFVC program;		
	and and an analysis	special extension (enter des	hand	o omonoidni,	Me Bi vo program,		
Part	II Basic Plan Informat	ion—enter all requested informa					
1a Nar	ne of plan			**************************************	1b Three-digit plan		
SCOTC	H PLYWOOD COMPANY, INC.				number (PN) ▶ 501		
					1c Effective date of plan 12/01/1996		
2a Plai	sponsor's name and address; in	nclude room or suite number (emp	oloyer, if for a single-	employer plan)	2b Employer Identification		
SCOTO	H PLYWOOD COMPANY, INC.				Number (EIN) 63-0501795		
00010	THE ETVICOR COMPANY, INC.				2c Sponsor's telephone		
					number		
PO BOX		РО ВОХ 3			800-936-4424		
FULTON, AL 36446 FULTON, AL 36446				2d Business code (see instructions) 321210			
Caution	: A penalty for the late or incon	nplete filing of this return/repor	t will be assessed	unless reasonable caus	se is established.		
Under pe	enalties of perjury and other pena	Ities set forth in the instructions. I	declare that I have	examined this return/rend	ort, including accompanying schedules, belief, it is true, correct, and complete.		
		\$					
SIGN	, lladek bo	M	8-21-13	Han K	Mater		
HERE	Signature of plan administrat	or	Date	Enter name of individua	gning as plan administrator		
	() \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1.	8 0 1	N 12			
SIGN HERE	~ WWW.M	0700	8-21-13	LHow K.	Horton		
	Signature of employer/plan s	ponsor	Date	Enter name of individua	al signing as employer or plan sponsor		
SIGN	·						
HERE							
Preparer	Signature of DFE 's name (including firm name, if a	pplicable) and address; include re	Date	Enter name of individua	al signing as DFE Preparer's telephone number		
	and the second s	pproducto) and address, molade it	oom or suite number	. (Optional)	(optional)		
				ļ			
For Pane	erwork Reduction Act Notice as	nd OMB Control Numbers, see t	the instructions for	Form FEOD			
ισιταμι	Simon reduction Act Notice at	ia omb control Numbers, 500 1	ភេទ ភេទភេពCពONS for	FORM 5500.	Form 5500 (2012) v. 120126		

	Form 5500 (2012)		Pa	ge 2			
3a	Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address			onsor Address	3b Administrator's EIN		
						1	dministrator's telephone umber
4	If the name and/or EIN of the plan sponsor has changed since the last retu EIN and the plan number from the last return/report:	ırn/report	iled for	this	plan, enter the name,	4b E	IN
а	Sponsor's name					4c P	N
5	Total number of participants at the beginning of the plan year					5	1251
6	Number of participants as of the end of the plan year (welfare plans comple	ete only lir	ies 6a,	6b,	6c, and 6d).		1201
а	Active participants	***************************************				6a	1251
b	Retired or separated participants receiving benefits	***************************************				6b	
С	Other retired or separated participants entitled to future benefits					6c	
d	Subtotal. Add lines 6a, 6b, and 6c	·····				6d	1251
е	Deceased participants whose beneficiaries are receiving or are entitled to r	receive be	nefits			6e	
f	Total. Add lines 6d and 6e.		•••••			6f	1251
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)				6g		
	Number of participants that terminated employment during the plan year wiless than 100% vested					6h	
7	Enter the total number of employers obligated to contribute to the plan (only	y multiem _l	oloyer p	olans	s complete this item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature of the plan provides welfare benefits, enter the applicable welfare feature code.						
9a	Plan funding arrangement (check all that apply) (1)	(1 (2 (3)))	efit :	arrangement (check all that Insurance Code section 412(e)(3) i Trust	nsuranc	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are	attached		here	General assets of the sp	onsor	had (Casinali III)
	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money	b G (1	eneral)		nedules H (Financial Inform	nation)	
	Purchase Plan Actuarial Information) - signed by the plan actuary	(2 (3 (4))		I (Financial Inform A (Insurance Inform C (Service Provide	mation) r Inform	ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5 (6		Н	D (DFE/ParticipatirG (Financial Trans		