Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Renefit 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), 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

2010

Pensio	on Benefit Guaranty Corporation				This Form is Open to Pu Inspection	ublic
Part I		tification Information				
For cale	ndar plan year 2010 or fiscal p			and ending 05/31/	2011	
A This	return/report is for:	a multiemployer plan;	= '	ble-employer plan; or		
		X a single-employer plan;	a DFE	(specify)		
			П			
B This	eturn/report is:	the first return/report;	<u></u>	the final return/report;		
		an amended return/report;	a short	plan year return/report (less t	han 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here				
D Chec	k box if filing under:	Form 5558;	automa	tic extension;	the DFVC program;	
		special extension (enter des	cription)			
Part	II Basic Plan Inform	nation—enter all requested informa	ation			
	ne of plan	c.			1b Three-digit plan number (PN) ▶	501
	,,				1c Effective date of pl 12/01/1996	an
	sponsor's name and address	s (employer, if for a single-employer poute no.)	plan)		2b Employer Identification Number (EIN)	ation
`	H PLYWOOD COMPANY, IN	,			63-0501795	
	2c Sponsor's telephone number 800-936-4424					
P.O. BOX 38 P.O. BOX FULTON, AL 36446 FULTON		38 AL 36446		2d Business code (ser instructions) 321210	е	
Caution	· A penalty for the late or in	complete filing of this return/repor	rt will he assesser	l unless reasonable cause i	is established	
	· · ·	<u> </u>				edules
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, 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	Filed with authorized/valid ele	ectronic signature.	09/03/2013	GLENN TOWNSEND		
HERE	Signature of plan adminis	trator	Date	Enter name of individual s	signing as plan administrator	
SIGN						
HERE	Signature of employer/pla	in sponsor	Date	Enter name of individual s	signing as employer or plan sp	onsor
SIGN						
HERE			!			

Signature of DFE Date Enter name
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the the plan number from the last return/report: a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d). a Active participants	e name, EIN and 5 6a	dministrator's telephone umber 100-936-4424 4b EIN 4c PN 958
the plan number from the last return/report: a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d). a Active participants	5 6a	4c PN 958
 a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d). a Active participants	6a	958
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d). a Active participants	6a	
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d). a Active participants	6a	
		962
		902
b Retired or separated participants receiving benefits	6b	
C Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a , 6b , and 6c	6d	962
	_	
Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		
f Total. Add lines 6d and 6e.	6f	962
g Number of participants with account balances as of the end of the plan year (only defined contribution plans	0.00	
complete this item)	6g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete thi		
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Charact	eristic Codes in the	instructions:
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteris 4A		
9a Plan funding arrangement (check all that apply) (1) Number Insurance 9b Plan benefit arrangement ((1) Insurance	check all that apply	·)
	n 412(e)(3) insuran	ce contracts
(3) Trust (3) Trust (4) General assets of the sponsor (4) General ass	sets of the sponsor	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, en	<u>'</u>	ched. (See instructions)
a Pension Schedules b General Schedules		
	ancial Information)	
	ancial Information –	,
ootuon/	urance Information) rvice Provider Inforr	
Ħ	E/Participating Plan	
	ancial Transaction	Schedules)

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 06/01/2010	and ending 05/31/2011
A Name of plan SCOTCH PLYWOOD COMPANY, INC.	B Three-digit plan number (PN)
C Plan sponsor's name as shown on line 2a of Form 5500 SCOTCH PLYWOOD COMPANY, INC.	D Employer Identification Number (EIN) 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	with services rendered to the plan or the person's position with the the plan received the required disclosures, you are required to
1 Information on Persons Receiving Only Eligible Indirect Compensat a 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	nis Part because they received only eligible
b If 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 instance)	the required disclosures for the service providers who
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	closure on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensation

	Schedule C (Form 5500) 2010	Page 2-	
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
1	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	rect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	irect compensation
	(b) Enter name and EIN or address of person	n who provided you disclosures on eligible indi	irect compensation

answered	I "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in to	otal compensation
			a) Enter name and FIN or	address (see instructions)		
BLUE CRC	OSS & BLUE SHIELD		450 RIVE	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		208798	Yes 🖺 No 🗌	Yes 🖺 No 🗍	0	Yes No X
		(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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No	(i). If floric, criter 0.	Yes No
1		(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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

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			a) Enter name and EIN or	address (see instructions)			
			a) Enter name and Ent of	address (see instructions)			
(b) Service Code(s)	Relationship to employer, 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?	
			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	(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)	(c) Relationship to employer, employee organization, or	Enter direct compensation paid by the plan. If none,	(e) Did service provider receive indirect compensation? (sources	(f) Did indirect compensation include eligible indirect compensation, for which the	Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of	

other than plan or plan

sponsor)

Yes No

plan received the required

disclosures?

Yes No

person known to be

a party-in-interest

enter -0-.

eligible indirect

compensation for which you answered "Yes" to element

(f). If none, enter -0-.

an amount or

estimated amount?

Yes No

Part I Service Provider Information (continued)		
3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment may questions for (a) each source from whom the service provider received \$1,000 or more in increase provider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	anagement, broker, or recordkeepindirect compensation and (b) each so	g services, answer the following burce 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
(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.
(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.
(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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Pa						
4	this Schedule.	ide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete 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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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			
а	Name:	·	b EIN:
С	Positio	n:	
d	Addres	s:	e Telephone:
Ex	planatior		
a	Name:		b EIN:
C	Positio	n:	D LIIV.
d	Addres		e Telephone:
_	7100100	•	• recognition.
Fx	planatior	1	
	piariatio	•	
а	Name:		b EIN:
С	Positio	n:	
d	Addres		e Telephone:
Fv	planatior		
	piariatioi	•	
а	Name:		b EIN;
C	Positio	n:	D LIIV,
d	Addres		e Telephone:
u	Addies	3 .	С тетернопе.
Ex	planatior	:	•
а	Name:		b ein;
С	Positio	n:	
d	Addres		e Telephone:
Ex	planatior	:	

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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), and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with

OMB Nos. 1210-0110 1210-0089

2010

		uie iiistruc	tions to the Form 5	500.			
Fascassianus	ion Benefit Guaranty Corporation				This Form is Open to P	ublic	
Part		tification Information					
_	endar plan year 2010 or fiscal p			and ending 05/31/2	2011		
A This	return/report is for:	a multiemployer plan;	a multipl	e-employer plan; or			
		X a single-employer plan;	a DFE (s	specify)			
B This	return/report is:	the first return/report;	☐ the final	return/report;			
		an amended return/report;	<u></u>	lan year return/report (less th	can 12 months)		
C if the	plan is a collectively-bargaine	ed plan, check here					
	ck box if filing under:	☐ Form 5558;	L3	c extension;	······ ☐ the DFVC program;		
	on son it thing arraor.	special extension (enter des		c extension,	Title DrvC program;		
Part	II Basic Plan Inform	nation—enter all requested information	,				
	ne of plan	action—enter an requested inform	alion		4b The Barrett	T	
	H PLYWOOD COMPANY, INC).			1b Three-digit plan number (PN) ▶	501	
				1c Effective date of plan 12/01/1996			
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) SCOTCH PLYWOOD COMPANY, INC.			2b Employer Identification Number (EIN) 63-0501795				
P.O. BOX 38				2c Sponsor's telephone number 800-936-4424			
FULTON, AL 36446		P.O. BOX 38 FULTON, AL 36446		2d Business code (see instructions) 321210			
Caution	: A penalty for the late or inc	omplete filing of this return/repor	t will be assessed	unless reasonable cause is	established		
Under po	enalties of perjury and other pe	enalties set forth in the instructions, s the electronic version of this return	declare that I have	examined this return/report i	neluding accompanying coho	dules,	
SIGN HERE	- any of!	Horan	8-21-13	1 1 11 1			
	Signature of plan administ	rator	Date	Enter name of individual sign	oning as plan administrator		
SIGN HERE	I long K	Horth	8-21-13	Amu K. 1	Hoston		
	Signature of employer/plan	sponsor	Date	Enter name of individual sig	gning as employer or plan spo	onsor	
SIGN HERE	W						
	Signature of DFE		Date	Enter name of individual sig	gning as DFE		
For Pape	Prwork Reduction Act Notice	and OMB Control Numbers, see	the instructions for	Form 5500	Form FEOO	(2010)	

Form 5500 (2010) v.092307.1

Form	5500	(2010)
UHH	2200	(ZUIU)

Page 2

						63	dministrator's EIN 3-0501795
	P.O. BOX 38 FULTON, AL 36446					nı	dministrator's telephone umber 10-936-4424
					•		
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	rn/repo	rt filed f	or this	s plan, enter the name, EII	N and	4b EIN
а	Sponsor's name						4c PN
5	Total number of participants at the beginning of the plan year					T	
6	Number of participants as of the end of the plan year (welfare plans comple	ete only	lines 6	a, 6b,	, 6c, and 6d).	5	958
а	Active participants					. 6a	962
	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	000
	Deceased participants whose heneficiaries are receiving as are actitled to the second se				962		
	Total. Add lines 6d and 6e					6f	962
g	Number of participants with account balances as of the end of the plan year	(only)	dofinad a	antri	hutian alasa	 	302
1	complete this item)					. 6g	
	Number of participants that terminated employment during the plan year with	h accru	ed bene	efits th	hat were	6h	
-	inter the total number of employers obligated to contribute to the plan (only	/ multie	mployer	r plan	is complete this item)	7	
b If I	f the plan provides pension benefits, enter the applicable pension feature content that the plan provides welfare benefits, enter the applicable welfare feature code A						
	Plan funding arrangement (check all that apply) 1)			nefit a	arrangement (check all tha	t apply)	**************************************
	2) Code section 412(e)(3) insurance contracts	Į.	(1) (2)	Ĥ	Insurance		
(3) Trust	1	(2)	Н	Code section 412(e)(3) in	nsurance	contracts
	General assets of the sponsor		(4)	Н	General assets of the so	onsor	
10 (heck all applicable boxes in 10a and 10b to indicate which schedules are a	ttache	i, and, w	here	indicated, enter the numb	er attach	ned. (See instructions)
	ension Schedules		Genera				,
((1)	П	H (Financial Inform	ation)	
(2			(2)	П	I (Financial Informa		mail Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary		(3)		A (Insurance Inform		· ·-··· ,
			(4)	X	C (Service Provider	r Informa	ition)
(3			(5)		D (DFE/Participatin		
	Information) - signed by the plan actuary		(6)		G (Financial Transa		