#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**HERE** 

Signature of DFE

## 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

2011

This Form is Open to Public Inspection

					Inspection	
Part I	Annual Report Iden	tification Information				
For cale	ndar plan year 2011 or fiscal p	plan year beginning 06/01/2011		and ending 05/31/2	2012	
A This	return/report is for:	a multiemployer plan;	a multip	e-employer plan; or		
		a single-employer plan;	☐ a DFF (	specify)		
		A single employer plan,	□ ~ = (			
<b>D</b>		the first return/report;	the final	return/report;		
<b>B</b> This	return/report is:	片	<u> </u>			
		an amended return/report;	a short p	plan year return/report (less th	nan 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here				
<b>D</b> Chec	k box if filing under:	Form 5558;	automat	ic extension;	X the DFVC program;	
		special extension (enter des	cription)		_	
Part	II Basic Plan Inform	nation—enter all requested informa	ation			
1a Nam	ne of plan				1b Three-digit plan	501
	H PLYWOOD COMPANY, INC	C.			number (PN) ▶	301
					1c Effective date of pla	an
					12/01/1996	
2a Plar	n sponsor's name and address	s, including room or suite number (Er	mployer, if for single	-employer plan)	2b Employer Identifica	ıtion
					Number (EIN)	
SCOTC	H PLYWOOD COMPANY, IN	C.			63-0501795	
					<b>2c</b> Sponsor's telephon number	ie
					800-936-4424	1
P.O. BO		P.O. BOX			2d Business code (see	
FULTON	N, AL 36446	FULTON,	AL 36446 Business code (see instructions)			•
					321210	
<b>2</b>						
		complete filing of this return/repor				
		enalties set forth in the instructions, las the electronic version of this return				
			T .	, <u>, , , , , , , , , , , , , , , , , , </u>		•
SIGN	Filed with authorized/valid ele	ectronic signature.	09/03/2013	GLENN TOWNSEND		
HERE						
	Signature of plan adminis	trator	Date	Enter name of individual si	gning as plan administrator	
CION						
SIGN HERE						
	Signature of employer/pla	n sponsor	Date	Enter name of individual si	gning as employer or plan sp	onsor
SIGN	I		I			

Date

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2011) v.012611

Enter name of individual signing as DFE

Form 5500 (2011) Page **2** 

	Plan administrator's name and address (if same as plan sponsor, enter "Same")  COTCH PLYWOOD COMPANY, INC.	1		ministrator's EIN
P.(	O. BOX 38 JLTON, AL 36446		3c Adr	ministrator's telephone mber 800-936-4424
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this p the plan number from the last return/report:	blan, enter the name, EIN a	and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	962
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6	<b>ic,</b> and <b>6d</b> ).	-	
а	Active participants		6a	924
b	Retired or separated participants receiving benefits		6b	
С	Other retired or separated participants entitled to future benefits		6c	
d	Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>		6d	924
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>		6f	924
g	Number of participants with account balances as of the end of the plan year (only defined contrib complete this item)	•	6g	
h	Number of participants that terminated employment during the plan year with accrued benefits the less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans		7	
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of	Plan Characteristic Codes	in the ir	nstructions:
b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of P 4A	lan Characteristic Codes in	n the ins	structions:
	(1)         X         Insurance         (1)         X           (2)         Code section 412(e)(3) insurance contracts         (2)         (3)         Trust         (3)         (3)         (4)           (4)         General assets of the sponsor         (4)         (4)	Irrangement (check all that Insurance Code section 412(e)(3) ir Trust General assets of the spo	nsurance	
10 a	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where  Pension Schedules  (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money  (2)		ation)	
	Purchase Plan Actuarial Information) - signed by the plan actuary (4)  (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (6)	A (Insurance Inform C (Service Provider D (DFE/Participatin G (Financial Transa	r Informang Plan I	Information)

# 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

2011

This Form is Open to Public Inspection.

For calendar plan year 2011 or fiscal plan year beginning 06/01/2011	and ending 05/31/2012
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 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 or more in total compensation (i.e., money or anything else of monetary value) in plan during the plan year. If a person received <b>only</b> eligible indirect compensation answer line 1 but are not required to include that person when completing the rem	connection with services rendered to the plan or the person's position with the or for which the plan received the required disclosures, you are required to
1 Information on Persons Receiving Only Eligible Indirect Con a Check "Yes" or "No" to indicate whether you are excluding a person from the remaindirect compensation for which the plan received the required disclosures (see in	ainder of this Part because they received only eligible
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person received only eligible indirect compensation. Complete as many entries as needed.	
(b) Enter name and EIN or address of person who provide	ded you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provide	ded you disclosure on eligible indirect compensation
(b) Enter name and EIN or address of person who provide	ded you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provide	ded you disclosures on eligible indirect compensation

Page <b>3</b> -	1		
Page <b>3</b> -	1		

answered	"Yes" to line 1a above	e, complete as many	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 t	otal compensation
			a) Enter name and EIN or	addrace (ean instructions)		
BLUE CRO	SS & BLUE SHIELD (	`	450 RIVE	RCHASE PARKWAY EAST HAM, AL 35298		
63-0103830	)					
(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		220283	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 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?  Yes No	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?
			Tes [] No []	Tes   NO		165   140
		(	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
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answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	ach person receiving, directly or	indirectly, \$5,000 or more in t	total compensation
	Relationship to employer, employee organization, or person known to be a party-in-interest   Party-in-interest   Cappensation paid of an amount or person known to be a party-in-interest   Party-in-interest   Cappensation paid of the plan. If none, enter -0   Party-in-interest   Cappensation paid of an amount or person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of person known to be a party-in-interest   Cappensation paid of paid of person known to be a party-in-interest   Cappensation paid of paid of paid of paid of paid of person known to be a party-in-interest   Cappensation paid of					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan	Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	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	Enter direct	(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	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?	(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

### Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compens or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in ind provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	nagement, broker, or recordkeepinq 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	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he 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 he 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 he indirect compensation.

Part II Service Providers Who Fail or Refuse to	Part II Service Providers Who Fail or Refuse to Provide Information				
4 Provide, to the extent possible, the following information for ear this Schedule.	ch service provide	r who failed or refused to provide the information necessary to complete			
(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 insection) (complete as many entries as needed)	structions)
а	Name		b ein:
С	Positio	n:	
d	Addres	es:	e Telephone:
Ex	olanatio	1:	
а	Name:		b EIN:
C	Positio		<u> </u>
d	Addres		<b>e</b> Telephone:
Exp	olanatio	n:	
а	Name:		<b>b</b> EIN:
С	Positio		
d	Addres		e Telephone:
Ex	olanatio	n:	
а	Name:		b EIN:
C	Positio		
d	Addres		e Telephone:
Ex	olanatio	n:	
а	Name:		b EIN:
C	Positio	n:	
d	Addres		<b>e</b> Telephone:
Ex	planatio	1:	

#### 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), 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

2011

Pensi	ion Benefit Guaranty Corporation				This Form is Open to P	ublic
Part I	Annual Report Iden	tification Information				
For cale	endar plan year 2011 or fiscal p	olan year beginning 06/01/2011		and ending 05/31/	2012	
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;	a short p	lan year return/report (less t	han 12 months).	
C If the	plan is a collectively-bargaine	d plan, check here			ъП	
	ck box if filing under:	☐ Form 5558;		c extension;	the DFVC program;	
	·	special extension (enter de	·	•		
Part	II Basic Plan Inform	nation—enter all requested inform	<del></del>			***************************************
	ne of plan H PLYWOOD COMPANY, INC				<b>1b</b> Three-digit plan number (PN) ▶	501
******					1c Effective date of pl 12/01/1996	an
	n sponsor's name and address H PLYWOOD COMPANY, INC	, including room or suite number (l	Employer, if for single-	employer plan)	2b Employer Identifica Number (EIN) 63-0501795	ation
P.O. BO	NY 38	0.000	V 00		2c Sponsor's telephor number 800-936-4424	
	v, AL 36446		P.O. BOX 38 FULTON, AL 36446		2d Business code (see instructions) 321210	е
			***************************************			
Caution	: A penalty for the late or inc	omplete filing of this return/repo	ort will be assessed	unless reasonable cause is	s established	
Under po	enalties of perjury and other pe	enalties set forth in the instructions s the electronic version of this retu	. I declare that I have	examined this return/report	including accompanying sche	dules,
SIGN HERE	May X	Motor	8-21-13	Anu K. X	hoton	
	Signature of plan administ	rator	Date	Enter name of individual s	igning as plan administrator	
SIGN HERE	Muy X	horbs.	8-21-13	Amy K. L	botan	
	Signature of employer/plar	sponsor	Date	Enter name of individual s	igning as employer or plan sp	onsor
SIGN HERE	V					
	Signature of DFE		Date	Enter name of individual si	igning as DFE	······································
For Dan	onwork Paduation Act Nation	THE PROPERTY OF THE PROPERTY O			×	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2011) v.012611

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Form	5500	(201	1)

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	3a Plan administrator's name and address (if same as plan sponsor, enter "Same") SCOTCH PLYWOOD COMPANY, INC.			3b Administrator's EIN 63-0501795			
P.O. BOX 38 FULTON, AL 36446					Parties and the second		ministrator's telephone ımber 800-936-4424
4	4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:				he name, EIN	and	4b EIN
а	Sponsor's name						4c PN
5	Total number of participants at the beginning of the plan year					5	962
6							1 902
a	a Active participants					6a	924
b	b Retired or separated participants receiving benefits					6b	
C	C Other retired or separated participants entitled to future benefits					6c	
d :	d Subtotal. Add lines 6a, 6b, and 6c					6d	924
e i	e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits				6e		
f Total. Add lines 6d and 6e				6f	924		
g i	g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)					6g	
h i	h Number of participants that terminated employment during the plan year with accrued benefits that were						
7	less than 100% vested  7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)				nis item)	6h 7	
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in							I
<b>b</b> 1	f the plan provides welfare benefits, enter the applicable welfare feature co	des from the	List of	Plan Characte	eristic Codes ir	n the ins	
	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that 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)	Н	Trust	on 4 (2(e)(3) in	surance	e contracts
(	4) General assets of the sponsor	(4)	H	_	sets of the spo	nsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and	l, when	re indicated, er	nter the numbe	er attach	ned. (See instructions)
	Pension Schedules	_		hedules			·
(	1) R (Retirement Plan Information)	(1)		1	nancial Informa	ation)	
(	2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	П	I (Fin	ancial Informa	tion – S	Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)		A (Ins	surance Inform	ation)	·
		(4)	$\boxtimes$	C (Se	rvice Provider	Informa	ation)
(;	SB (Single-Employer Defined Benefit Plan Actuarial	(5)	Ц		E/Participating		•
	Information) - signed by the plan actuary	(6)		G (Fin	nancial Transa	ction So	chedules)