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

2014

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
REXCO, INC. OCCUPATIONAL INJURY PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 06/30/2008

2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)
REXCO, INC.

1104 MILDRED DRIVE
PORT LAVACA, TX 77979-5564

1104 MILDRED DRIVE
PORT LAVACA, TX 77979-5564

2b Employer Identification Number (EIN)
74-1467107

2c Plan Sponsor's telephone number
361-552-5371

2d Business code (see instructions)
237310

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 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 HERE	Filed with authorized/valid electronic signature.	08/06/2015	IVAN CHEONG
	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
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)
IVAN CHEONG
EMPLOYER'S EDGE ADMINISTRATIVE SVCS
508 TWILIGHT TRAIL
SUITE 201
RICHARDSON, TX 75080

Preparer's telephone number (optional)
972-437-1707

3a	Plan administrator's name and address [X] Same as Plan Sponsor	**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/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	**4b**	EIN
a	Sponsor's name	**4c**	PN

5	Total number of participants at the beginning of the plan year	**5**	200
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	200
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	180
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	180
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans 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 this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4F 4H 4L

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[ ] Insurance	**(1)**	[ ] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[ ] Trust	**(3)**	[ ] Trust
(4)	[X] General assets of the sponsor	**(4)**	[X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1) [ ] **R** (Retirement Plan Information)

(2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1) [ ] **H** (Financial Information)

(2) [ ] **I** (Financial Information – Small Plan)

(3) [ ] ___ **A** (Insurance Information)

(4) [ ] **C** (Service Provider Information)

(5) [ ] **D** (DFE/Participating Plan Information)

(6) [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

2014 Plan Information Worksheet

Status: Not Ready

Plan Sponsor Information

Plan Sponsor's Name
Rexco, Inc.

Plan Sponsor's Mailling Address — Foreign C
1104 Mildred Drive

Abbreviated Plan Sponsor's Name
Rexco, Inc.

Plan Sponsor's Mailing City, Province, State and ZIP
Port Lavaca TX 77979-5564

Plan Sponsor's Doing Business As Name

Plan Sponsor's Location Address — Foreign C
1104 Mildred Drive

Plan Sponsor's Care Of Name

Plan Sponsor's Location City, Province, State and ZIP
Port Lavaca TX 77979-5564

Plan Sponsor's EIN
74-1467107

Plan Sponsor's Phone Number
(361) 552-5371

Plan Administrator Information

[X] Same as Plan Sponsor

Plan Administrator's Name

Plan Administrator's Address — Foreign C

Plan Administrator's Care Of Name

Plan Administrator's City, Province, State and ZIP

Plan Administrator's EIN

Plan Administrator's Phone Number

Plan Information

Plan Name
Rexco, Inc. Occupational Injury Plan

Business Code
237310

Filing for Plan Year: 2014

DFE Plan C

Plan Year Begins MM/DD/YYYY 01/01/2014 Ends MM/DD/YYYY 12/31/2014

Abbreviated Plan Name
Rexco, Inc. Occupational Injury Plan

Tax Year Begins MM/DD/YYYY 01/01/2014 Ends MM/DD/YYYY 12/31/2014

Three-digit Plan Number
501

Plan ID

Name Control

EIN for PBGC Forms

Effective Date of Plan
06/30/2008

Transmitter Information

Transmitter's TIN
26-3152309

Transmitter Control Code (TCC)

Contact Name
Ivan Cheong

Transmitter's Name
Ivan Cheong

Contact Telephone Number
(972) 437-1707

Company Name
Employer's Edge Administrative Services

Contact E-Mail Address
icheong@empedgeservices.com

Company Mailing Address — Foreign C
508 Twilight Trail, Suite 201

Company City, Province, State and ZIP
Richardson TX 75080

Do NOT File with IRS, DOL or PBGC

Preparer Information

Preparer's Name
Ivan Cheong

Preparer's Firm Name
Employer's Edge Administrative Svcs

Preparer's Address
508 Twilight Trail
Suite 201

Foreign C

Preparer's City, Province, State and ZIP
Richardson TX 75080

Preparer's Phone Number
(972) 437-1707

Trust Information

Name of Trust

Trust EIN

Signers, Service Providers and Interested Individuals

☒ Notify Plan Administrator

Contact Name
Dennis Redding

Contact ID

Contact Phone Number

E-Mail Address
dennis@rexcoinc.com

☒ Notify Other

Contact Name
Ivan Cheong

Contact ID

Contact Phone Number
(972) 437-1707

E-Mail Address
icheong@empedgeservices.com

C Notify

Contact Name

Contact ID

Contact Phone Number

E-Mail Address

C Notify

Contact Name

Contact ID

Contact Phone Number

E-Mail Address

C Notify

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Contact Phone Number

E-Mail Address

C Notify

Contact Name

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E-Mail Address

C Notify

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Contact ID

Contact Phone Number

E-Mail Address

C Notify

Contact Name

Contact ID

Contact Phone Number

E-Mail Address

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

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

OMB Nos. 1210-0110
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- ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☒ Form 5558;
- ☐ automatic extension;
- ☐ the DFVC program;
- ☐ special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
Rexco, Inc. Occupational Injury Plan

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 06/30/2008

2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)
Rexco, Inc.

1104 Mildred Drive

Port Lavaca TX 77979-5564
1104 Mildred Drive

Port Lavaca TX 77979-5564

2b Employer Identification Number (EIN) 74-1467107

2c Plan Sponsor's telephone number (361) 552-5371

2d Business code (see instructions) 237310

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 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 HERE	John W. Harrison	07/31/2015	John W. Harrison
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	John W. Harrison	07/31/2015	John W. Harrison
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
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)

Ivan Cheong
Employer's Edge Administrative Svcs
508 Twilight Trail
Suite 201
Richardson TX 75080

Preparer's telephone number (optional)
(972) 437-1707

3a	Plan administrator's name and address [X] Same as Plan Sponsor	**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/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	**4b**	EIN
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b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [ ] **A** (Insurance Information)
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- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

Form **5558**
(Rev. August 2012)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

▶ **For Privacy Act and Paperwork Reduction Act Notice, see instructions.**
▶ **Information about Form 5558 and its instructions is at *www.irs.gov/form5558***

OMB No. 1545-0212

File With IRS Only

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions)
Rexco, Inc.

Number, street, and room or suite no. (If a P.O. box, see instructions)
1104 Mildred Drive

City or town, state, and ZIP code
Port Lavaca TX 77979-5564

B **Filer's identifying number (see instructions)**
Employer identification number (EIN) (9 digits XX-XXXXXXX)
74-1467107

Social security number (SSN) (9 digits XXX-XX-XXXX)

C Plan name	Plan number	Plan year ending— MM	DD	YYYY
Rexco, Inc. Occupational Injury Plan	5 0 1	12	31	2014

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

1 ☐ Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above.

2 I request an extension of time until 10 / 15 / 2015 to file Form 5500 series (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.

3 I request an extension of time until / / to file Form 8955-SSA (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application **is automatically approved** to the date shown on line 2 and/or line 3 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

Part III Extension of Time To File Form 5330 *(see instructions)*

4 I request an extension of time until / / to file Form 5330.
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax . . . . . ▶ **a**

b Enter the payment amount attached . . . . . ▶ **b**

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . ▶ **c**

5 **State in detail why you need the extension:**

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ▶ **Date ▶**