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

2011

This Form is Open to Public

Part I Annual Report Identification Information For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011 A This return/report is for: a multiemployer plan; a multiple-employer plan; or a DFE (specify) B This return/report is: the first return/report; the final return/report; a short plan year return/report (less than 12 months). C If the plan is a collectively-bargained plan, check here.	
A This return/report is for: a multiemployer plan; a single-employer plan; a DFE (specify) a DFE (specify) b This return/report is: the first return/report; an amended return/report; an amended 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: Form 5558; automatic extension; the DFVC program; special extension (enter description) Part II Basic Plan Information—enter all requested information 1b Three-digit plan	
B This return/report is: the first return/report; an amended return/report; an amended return/report; b The plan is a collectively-bargained plan, check here. D Check box if filing under: Form 5558; automatic extension; special extension (enter description) Part II Basic Plan Information—enter all requested information 1b Three-digit plan	
B This return/report is: the first 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: Form 5558; automatic extension; special extension (enter description) Part II Basic Plan Information—enter all requested information 1b Three-digit plan	
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	
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	
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D Check box if filing under: Form 5558; special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Three-digit plan	
D Check box if filing under: Form 5558; special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Three-digit plan	
special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Three-digit plan	
Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Three-digit plan	
1a Name of plan 1b Three-digit plan	
(5.0)	
	503
1c Effective date of plan	
01/01/1994	
2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan) 2b Employer Identification	ก
Number (EIN) HATTIESBURG MEDICAL PARK MANAGEMENT CORP 64-0604714	
HATTIESBURG MEDICAL PARK MANAGEMENT CORP 64-0604714 2c Sponsor's telephone	
number	
100 WEST PINE STREET 100 WEST PINE STREET 601-583-3232	
HATTIESBURG, MS 39401 HATTIESBURG, MS 39401 Zd Business code (see	
instructions) 623000	
023000	
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 schedul	
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 comple	ne.
SIGN Filed with authorized/valid electronic signature. 07/27/2012 STEPHEN A. WORREL	
SIGN Filed with authorized/valid electronic signature. 07/27/2012 STEPHEN A. WORREL 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	
	sor
SIGN	sor
HERE Signature of DFE Date Enter name of individual signing as DFE	sor

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

Form 5500 (2011) v.012611

Form 5500 (2011) Page **2**

	Plan administrator's name and address (if same as plan sponsor, enter "San TTIESBURG MEDICAL PARK MANAGEMENT CORP	ne")				dministrator's EIN -0604714
	O WEST PINE STREET TTIESBURG, MS 39401					Iministrator's telephone umber 601-583-3232
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:	n/report filed t	for thi	is plan, enter the name, EIN	and	4b EIN
а	Sponsor's name					4c PN
5	Total number of participants at the beginning of the plan year				5	415
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6	a, 6b	o, 6c, and 6d).		
а	Active participants				. 6a	444
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	444
u						744
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefit	S		. 6e	
f	f Total. Add lines 6d and 6e.				. 6f	
g	Number of participants with account balances as of the end of the plan year complete this item)				6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested				6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemploy	er pla	ans complete this item)	7	
8a b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A 4B 4D 4H					
9a	Plan funding arrangement (check all that apply) (1) Insurance	9b Plan b	enefi	it arrangement (check all tha Insurance	at apply)	
	(1) Insurance (2) Code section 412(e)(3) insurance contracts	(1)	-	Code section 412(e)(3) i		ce contracts
	(3) Trust	(3)		Trust	modram	
	(4) General assets of the sponsor	(4)	X	General assets of the sp	onsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and	, whe	ere indicated, enter the numb	oer attac	ched. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information)	b Gene	ral S	chedules H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	×	I (Financial Inform A (Insurance Inform C (Service Provide	mation) er Inform	nation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)		D (DFE/Participation G (Financial Trans	-	

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.

Insurance companies are required to provide the information

OMB No. 1210-0110

			RISA section 103(a)(2).	11113 1 01	m is Open to Public Inspection	
For calendar plan year 20	11 or fiscal plan	year beginning 01/01/2011	and en		•	
A Name of plan HATTIESBURG MEDICA	L PARK / CON	VA REST GROUP INSURANCE I	DL A NI	e-digit number (PN)	503	
C Plan sponsor's name a HATTIESBURG MEDICA			D Emplo	yer Identification Number (04714	EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.					
1 Coverage Information:						
(a) Name of insurance ca		CANADA				
	(e) Approximate number of Policy or contract year					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	(f) From	(g) To	
38-1082080	80802	010829	426	01/01/2011	12/31/2011	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid					
12069						
3 Persons receiving com	missions and fe	es. (Complete as many entries a	is needed to report all persons).			
		•	or other person to whom commiss	ions or fees were paid		
BANCORPSOUTH INS S	ERVICES INC		OX 250 PORT, MS 39502			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	(e) Organization code		
	9920				3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid		
BANCORPSOUTH INS SERVICES INC 4041 ESSEN LN # 440 BATON ROGUE, LA 70809						
(b) Amount of colors	nd hoos	Fees	and other commissions paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code	
·	2149				3	
For Paperwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500	Scher	dule A (Form 5500) 2011	

Schedule A (Form 5500)	2011	Page 2 - 1]		
(a) Na	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid		
(4)	and address of the agon, siene	., c. carer percent to innern			
(L) A		Fees and other commission	s paid	(-) ()	
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code	
•	, ,				
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
	I			T	
(b) Amount of sales and base		Fees and other commission		(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid		
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid		
	I				
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization	
commissions paid	(c) Amount		(d) Fulpose	code	
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
		, ,	•		
		Fees and other commission	s naid	T.,	
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code	
Commissions paid	(o) / anount		(±). 3.5000		
				1	

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier mag	y be treated	d as a unit for purposes of
4	Curre	nt value of plan's interest under this contract in the general account at year	end		4	
_		nt value of plan's interest under this contract in separate accounts at year e			. 5	
6	Contr	acts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			. 6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
	;	Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	,		
	-			3		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year			1 10	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
	ı					
					7-(0)	
	_	(6)Total additions			7c(6)	0
		otal of balance and additions (add b and c(6)).			. 7d	
		Deductions:	70/4			
	,	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	,	(2) Administration charge made by carrier	. 7e(2)			
	,	3) Transferred to separate account	. 7e(3)			
	(4) Other (specify below)	. 7e(4)			
	١	•				
	(5) Total deductions			. 7e(5)	0
	,	Balance at the end of the current year (subtract e(5) from d)			. 7f	

Schedule A (Form 5500) 2011	Page 4
information may be combined for reporting purpose	employees of the same employer(s) or members of the same employee organizations(s), the if such contracts are experience-rated as a unit. Where contracts cover individual employed the carrier may be treated as a unit for purposes of this report.
	Dental
erience-rated contracts:	
Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	9a(2)
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	9a(4)
Benefit charges (1) Claims paid	9b(1)
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	9b(3)
(4) Claims charged	9b(4)
Remainder of premium: (1) Retention charges (on an a	
(A) Commissions	· · · ·
(B) Administrative service or other fees	
(C) Other specific acquisition costs	9c(1)(C)

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

99201

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid.....

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(D) 9c(1)(E)

9c(1)(F)

¹² If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				tion	This Fo	rm is Open to Public Inspection	
For calendar plan year 20	11 or fiscal pla	an year beginning 01/01/201	1	and en	nding 12/3	1/2011	
A Name of plan HATTIESBURG MEDICA	L PARK / CO	NVA REST GROUP INSURANC	CE PLAN		e-digit number (PN)	•	503
C Plan sponsor's name a				D Emplo	oyer Identifica 04714	tion Number	(EIN)
		rning Insurance Contract individual contracts grouped a					
(a) Name of insurance ca							
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate repersons covered	at end of	(f) i	Policy or c	ontract year (g) To
22-2311816	39217	AJS00585-10	policy or contra	ct year 144	01/01/201		01/01/2012
2 Insurance fee and com descending order of the		 mation. Enter the total fees and t	cotal commissions paid.	List in item 3	I 3 the agents, I	orokers, and	other persons in
	(a) Total amount of commissions paid (b) Total amount of fees paid						
3		0		1			0
Persons receiving com		fees. (Complete as many entried and address of the agent, broke			cione or fees v	vere paid	
(1) A		•	ees and other commissi				
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code
·		`,					
	(a) Name	and address of the agent, broke	er, or other person to who	om commiss	sions or fees w	vere paid	
	(,)	.					
(b) Amount of sales ar	nd base	Ę	ees and other commissi	ons paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500)	2011	Page 2 - 1]		
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid		
(4)	and address of the agont, siene	., c. carer percent to innern			
(L) A		Fees and other commission	s paid	(-) ()	
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code	
•	, ,				
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
	T			T	
(b) Amount of sales and base		Fees and other commission		(e) Organization	
commissions paid	(c) Amount		(d) Purpose	code	
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid		
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid		
	I				
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization	
commissions paid	(c) Amount		(d) Fulpose	code	
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid		
		, ,	•		
		Fees and other commission	s naid	T.,	
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code	
Commissions paid	(o) / anount		(±). 3.5000		
				1	

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ay		•

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier mag	y be treated	d as a unit for purposes of
4	Curre	nt value of plan's interest under this contract in the general account at year	end		4	
_		nt value of plan's interest under this contract in separate accounts at year e			. 5	
6	Contr	acts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			. 6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
	;	Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	,		
	-			3		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year			1 10	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
	ı					
					7-(0)	
	_	(6)Total additions			7c(6)	0
		otal of balance and additions (add b and c(6)).			. 7d	
		Deductions:	70/4			
	,	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	,	(2) Administration charge made by carrier	. 7e(2)			
	,	3) Transferred to separate account	. 7e(3)			
	(4) Other (specify below)	. 7e(4)			
	١	•				
	(5) Total deductions			. 7e(5)	0
	,	Balance at the end of the current year (subtract e(5) from d)			. 7f	

Pa	age 4		
experien	ver(s) or members of the same er ce-rated as a unit. Where contra- unit for purposes of this report.		
c [g [k [Vision Supplemental unemployment PPO contract	d [] h [] I []	Life insurance Prescription drug Indemnity contract
>-(4)			
9a(1) 9a(2)			
)=(2)		-	

Pa	art III	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same group of employees of the same employer(s) or members of the information may be combined for reporting purposes if such contracts are experience-rated as a unit. When					
		the entire group of such individual contracts v					s cover individual employees,
8	Bene	fit and contract type (check all applicable boxes)			·		
	а	Health (other than dental or vision)	b Dental	сГ	Vision		d Life insurance
	e 🗀	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	olovment	h Prescription drug
	. <u>\</u>		i HMO contract	·	PPO contract	oloyilloll	_ H
	' '	Stop loss (large deductible)	I HIMO contract	k_	PPO contract		I Indemnity contract
	m _	Other (specify)					
9	Evne	rience-rated contracts:					
•		remiums: (1) Amount received		9a(1)			
		Increase (decrease) in amount due but unpaid		- :-:			
	,	3) Increase (decrease) in unearned premium res		· · · ·			
		4) Earned ((1) + (2) - (3))				9a(4)	
	_ `	Benefit charges (1) Claims paid					
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in c(2) .)		9e	
10	Non	experience-rated contracts:					
	_	Total premiums or subscription charges paid to o				10a	414837
		If the carrier, service, or other organization incuring the contract or policy, other than report	, ,		•	10b	

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	_

Specify nature of costs >

Schedule A (Form 5500) 2011

¹² If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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

pursuant to ERISA section 103(a)(2).					This For	m is Open to Public Inspection	
For calendar plan year 20	11 or fiscal pl	an year beginning 01/01/201	1	and end	ding 12/3	1/2011	
A Name of plan HATTIESBURG MEDICA	AL PARK / CO	NVA REST GROUP INSURANC	CE PLAN	B Three plan i	e-digit number (PN)	•	503
C Plan sponsor's name a	AL PARK MAN	IAGEMENT CORP		64-0604	4714	tion Number	
Part I Informati on a separa	on Concer te Schedule A	rning Insurance Contract. Individual contracts grouped a	t Coverage, Fees, a	nd Comn can be repo	nissions F rted on a sin	Provide inform gle Schedule	nation for each contract A.
1 Coverage Information:							
(a) Name of insurance ca SUN LIFE AND HEALTH		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu	_		Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) F	rom	(g) To
06-0893662 80926 036-7291-00		40)2	01/01/201	1	01/01/2012	
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents, b	orokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
12402 0						0	
3 Persons receiving com	nmissions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		and address of the agent, broke			ons or fees w	vere paid	
BANCORPSOUTH INS S	SERVICES IN). BOX 250 LFPORT, MS 39501				
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa	nid	(c) Amount	(d) Purpose			(e) Organization code	
12402							3
	(a) Name	and address of the agent, broke	er, or other person to whor	n commission	ons or fees v	vere paid	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount	1	(d) Purpose	1		(e) Organization code

Schedule A (Form 5500)	2011	Page 2 - 1]					
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid					
(4)	and address of the agont, siene	., c. carer percent to innern						
(L) A		Fees and other commission	s paid	(-) ()				
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code				
•	, ,							
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid					
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization				
commissions paid	(c) Amount		(d) Purpose	code				
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid					
	I			T				
(b) Amount of sales and base		Fees and other commission		(e) Organization				
commissions paid	(c) Amount		(d) Purpose	code				
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid					
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid					
	I							
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization				
commissions paid	(c) Amount		(d) Fulpose	code				
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid					
		, ,	•					
		Fees and other commission	s naid	T.,				
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code				
Commissions paid	(o) / anount		(±). 3.5000					
				1				

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ay		•

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier mag	y be treated	d as a unit for purposes of
4	Curre	nt value of plan's interest under this contract in the general account at year	end		4	
_		nt value of plan's interest under this contract in separate accounts at year e			. 5	
6	Contr	acts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			. 6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
	;	Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	,		
	-			3		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year			1 10	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
	ı					
					7-(0)	
	_	(6)Total additions			7c(6)	0
		otal of balance and additions (add b and c(6)).			. 7d	
		Deductions:	70/4			
	,	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	,	(2) Administration charge made by carrier	. 7e(2)			
	,	3) Transferred to separate account	. 7e(3)			
	(4) Other (specify below)	. 7e(4)			
	١	•				
	(5) Total deductions			. 7e(5)	0
	,	Balance at the end of the current year (subtract e(5) from d)			. 7f	

Schedule A (Form 5500) 2011	Page 4
	same employer(s) or members of the same employee organizations(s), the are experience-rated as a unit. Where contracts cover individual employees, treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes)	
Health (other than dental or vision)	c Vision
Temporary disability (accident and sickness) f Long-term disabilit	ity g Supplemental unemployment h Prescription drug
Stop loss (large deductible) j HMO contract	k PPO contract
Other (specify)	_
erience-rated contracts:	
Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	9a(4)
Benefit charges (1) Claims paid	. 9b(1)
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	9b(3)
(4) Claims charged	9b(4)
Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

124024

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received...... (2) Increase (decrease) in amount due but unpaid.....

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees

(C) Other specific acquisition costs.....

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(B)

9c(1)(C)

9c(1)(D) 9c(1)(E)

9c(1)(F)

¹² If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

2011

This Form is Open to Public Inspection.

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011	and ending 12/31/2011	
A Name of plan HATTIESBURG MEDICAL PARK / CONVA REST GROUP INSURANCE PLAN	B Three-digit plan number (PN) ▶	503
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Nun	nber (EIN)
HATTIESBURG MEDICAL PARK MANAGEMENT CORP	64-0604714	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the informat or more in total compensation (i.e., money or anything else of monetary value) in conn plan during the plan year. If a person received only eligible indirect compensation for answer line 1 but are not required to include that person when completing the remaind 1 Information on Persons Receiving Only Eligible Indirect Compelation Check "Yes" or "No" to indicate whether you are excluding a person from the remainder	ection with services rendered to the pla which the plan received the required di er of this Part.	an or the person's position with the sclosures, you are required to
indirect compensation for which the plan received the required disclosures (see instruc	•	
b If you answered line 1a "Yes," enter the name and EIN or address of each person pro- received only eligible indirect compensation. Complete as many entries as needed (see		service providers who
(b) Enter name and EIN or address of person who provided y	ou disclosures on eligible indirect comp	pensation
(b) Enter name and EIN or address of person who provided y	rou disologuro on oligible indirect comp	ongotion
(b) Enter hame and Env or address or person who provided y	ou disclosure on eligible indirect comp	erisation
(b) Enter name and EIN or address of person who provided you	ou disclosures on eligible indirect comp	pensation
(a) Ellion haine and Ellit of dadress of person time provided).	ou dississance on singlete indirect comp	- Constant
(b) Enter name and EIN or address of person who provided you	ou disclosures on eligible indirect comp	pensation
, , , , , , , , , , , , , , , , , , , ,	0	

Page 3 -	1	

				r Indirect Compensation		
				ch person receiving, directly or ne plan or their position with the		
		(a) Enter name and EIN or	address (see instructions)		
UNITEDHE	ALTHCARE INSURAI	`	9900 BRE	N ROAD MN008-T390 NKA, MN 55343		
36-273957	1					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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?
2 49	CLAIMS PROCESSOR	236055	Yes X No	Yes No 🛚	0	Yes X No
		(a) Enter name and EIN or	address (see instructions)		
BANCORP	SOUTH INS SERVICE	ES, INC.	P.O. BOX GULFPO	C 250 RT, MS 39502-0250		
72-1381997	7					
(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?
55	BROKER	0	Yes X No	Yes No X	19456	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?	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	or Indirect Compensation ach person receiving, directly or the 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, 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	
			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

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 inc 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 recordkeepinç direct 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 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		
d	Addres		e Telephone:
Exp	olanatio	n:	
а	Name:		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		e Telephone:
Ex	planatio	1:	

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

Annual Return/Roport of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4085 of the Employee Retirement income Security Act of 1974 (ERISA) and sections 6047(e), 6067(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110 1210 - 0089

Administration		n sentre all entres it the instructions to	he Form 5500.		This Form is Open to
Pension Benefit Guaranty Corporation	_	44.5			Public Inspection
Partil Annual Repo	ort Identification Info	ormation	033	10/2	1/2011
For calendar plan year 201				· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·
A This return/report is for:	a multiemployer pla)(iliple employer pla E (specify)	iit) Ot
•	X a single-employer p.	lan;	∐ «рп		
B This return/report is:	the first return/repo	r š :	∏ the fi	nal return/report;	
B This return/report is:	an amended return		asho	nt plan year returr	v/report (less than 12 mont)
C If the plan is a collectively b	pargained plan, check here	***********************			П
D Check box if filing under:	Form 5558;		∐ autor	natic extension;	the DFVO program
nontransitives - 174	special extension (c	enter description)			
to reference and a second seco	nformation - enter all re	iquesteo imormation		1b Three-digit	
1a Name of plan HATTIESBURG MED:	COAL PARK / CO	NVA REST		plan numb	
GROUP INSURANCE		, , , , , , , , , , , , , , , , , , , ,		to Effective d	
				01/01	
2a Plan sponsor's name and add	fress, including room or suite	number (Employer, if for	e single-employer plan)	64-06	
HATTIESBURG MED	ICAL PARK MANA	AGEMENT CORE	•	20 Sponsor's (601)583	telephone number -3232
	2005 ET ER (T)			2d Business 62300	oode (see instructions) O
TOO WEST PINE S	LKEET				
HATTIESBURG	MS 3	39401			
TOU WEST PINE S	PREET				
HATTESBURG	MS	39401	to congress the	i eausa elegane	s established.
Saution: A penalty for the lat			to the second and the second and a second	nasnvino schedujes, st	atements and etlechments, as well
Und a senative of periors and other pena as the decironic version of this returning	alties sat forth in the instructions, I do	ge and belief, it is true, correct	, and complete.		
SIGN STAN []	Markel	7/27/12	STEPHEN A.	WORREL	
Signature of plan adn	ninistrator	Date	Enter name of Individu	al signing as plan	administrator
sian					
HERE Signature of employe	or/nlan enonger	Date	Enter name of Individu	al signing as emp	loyer or plan sponsor
Olithurnie of subjoye	Minis abanco.				
BICIN					
Signature of DFE		Date	Enter name of individu		Form 5500 (20
For Paperwork Reduction Ac	A Notice and OMB Contro	ol Numbers, see the i	nstructions for Form b	300,	V.012