### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2012

This Form is Open to Public Inspection

						Inspection	
Part I	Annual Report Identifi	cation Information					
For caler	ndar plan year 2012 or fiscal plan	year beginning 01/01/2012		and ending 12/3	31/2012		
A This r	eturn/report is for:	a multiemployer plan;	a multiple	e-employer plan; or			
		x a single-employer plan;	a DFE (s	pecify)			
		_	_				
<b>B</b> This return/report is: ☐ the first return/report; ☐ the final return/report;							
	·	an amended return/report;	a short p	lan year return/report (les	ss than 12 m	onths).	
C If the	plan is a collectively-bargained p	olan, check here	<u> </u>			<b>▶</b> □	
	k box if filing under:	☐ Form 5558;	_	c extension;		ы e DFVC program;	
<b>D</b> Office	Cook if filling drider.	special extension (enter desc	ш	,	□	· · · · · · · · · · · · · · · · · ·	
Dowt	I Danie Dlan Informati						
Part I		ion—enter all requested informat	ion		16	Thurs distributes	
1a Nam	•	VA REST GROUP INSURANCE P	ΙΔΝ		10	Three-digit plan number (PN) ▶	503
TIATTIE	DONG WEDIOAET ANN TOON	TAREST SKOOT INSORANGET	LAIN		1c	Effective date of pl	an
						01/01/1994	
2a Plan	sponsor's name and address; in	nclude room or suite number (empl	oyer, if for a single-	employer plan)	2b	Employer Identifica	ation
	DUDO MEDIOM, DADICMANIA	OFMENT CORP				Number (EIN) 64-0604714	
HATTIES	SBURG MEDICAL PARK MANAC	GEMENT CORP			20	Sponsor's telephor	ne
					number		ie
400 M/E	PT DINE CTREET	400 MEOT	DINE OTDEET			601-583-3232	2
	ST PINE STREET BBURG, MS 39401		PINE STREET URG, MS 39401		2d	2d Business code (see	
						instructions) 623000	
						023000	
Caution	A penalty for the late or incom	nplete filing of this return/report	will be assessed	unless reasonable caus	se is establi	shed.	
		alties set forth in the instructions, I have electronic version of this return/					
Statemen	ns and attachments, as well as the	Te electronic version of this return	report, and to the b	est of my knowledge and	i beller, it is ti	Tue, correct, and con	ipiete.
SIGN							
HERE	Filed with authorized/valid electron	ŭ .	07/12/2013	STEPHEN A. WORRE			
	Signature of plan administrate	or	Date	Enter name of individua	al signing as	plan administrator	
SIGN							
HERE							
	Signature of employer/plan sp	ponsor	Date	Enter name of individua	al signing as	employer or plan sp	onsor
O.O.							
SIGN HERE							
	Signature of DFE		Date	Enter name of individua			
					telephone number		
60					601-987-4300		
EUBANK	EUBANK, BETTS, HIRN, WOOD, PLLC						
	5 NORTH N, MS 39211						
JACKSO	14, IVIO 09211						

Form 5500 (2012) Page **2** 

3a	Plan administrator's name and address Same as Plan Sponsor Name	Same as Plan Sponsor Address	<b>3b</b> Administrator's EIN
			3c Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed for this plan, enter the name,	4b EIN
а	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year		5 444
6	Number of participants as of the end of the plan year (welfare plans complet	e only lines <b>6a, 6b, 6c,</b> and <b>6d</b> ).	
а	Active participants		. <b>6a</b> 481
ű	700VO participanto		. 00
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>		. <b>6d</b> 481
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	. 6e
f	Total. Add lines <b>6d</b> and <b>6e</b>		. 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 less than 100% vested		. 6h
7	Enter the total number of employers obligated to contribute to the plan (only		7
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List of Plan Characteristics Cod	es in the instructions:
b	If the plan provides welfare benefits, enter the applicable welfare feature coo	les from the List of Plan Characteristics Code	s in the instructions:
	4A 4B 4D 4H		
02	Disp funding every general (should all that explu)	Oh Dien honefit arrangement (about all the	ot apply)
Ja	Plan funding arrangement (check all that apply)  (1) Insurance	9b Plan benefit arrangement (check all that (1) Insurance	агарріу)
	(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 s	ponsor
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the num	ber attached. (See instructions)
а	Pension Schedules	b General Schedules	
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	mation)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		nation – Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3) X 3 A (Insurance Information)	,
	actuary	(4) X C (Service Provide	•
	(3) SR (Single-Employer Defined Reposit Dian Actuaries	<del> </del>	ing Plan Information)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6) G (Financial Trans	
	mornialism, signed by the plant delicary	(o) Li di indicidi Hali	caca.c.i Conocacioo,

## **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

2012

- ension benefit dualanty of	Siporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection	
For calendar plan year 20	12 or fiscal plai	n year beginning 01/01/2012	and en	ding 12/31/2012		
A Name of plan HATTIESBURG MEDICAL	L PARK / CON	VA REST GROUP INSURANCE F	OL A NI	e-digit number (PN)	503	
C Plan sponsor's name as shown on line 2a of Form 5500 HATTIESBURG MEDICAL PARK MANAGEMENT CORP  D Employer Identification Number (EIN) 64-0604714						
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		F CANADA				
			(e) Approximate number of	Policy or o	contract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	( <b>g</b> ) To	
38-1082080	80802	010829	516	01/01/2012	12/31/2012	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid						
18302						
3 Persons receiving com	missions and fo	ees. (Complete as many entries a	s needed to report all persons)			
• 1 dischio receiving deni		and address of the agent, broker, o	· · · · · ·	ions or fees were paid		
BANCORPSOUTH INS S		P.O. B	OX 250 PORT, MS 39502	p		
		GOLFF	OK1, WS 39302			
		Face			1	
(b) Amount of sales an commissions pa		(c) Amount	and other commissions paid (d) Purpose	(e) Organization code		
COMMISSIONS PA	14323	(C) Amount	(u) i diposi	<u> </u>	(e) Organization code	
	020					
	(a) Name a	and address of the agent, broker, c	or other person to whom commiss	ions or fees were paid		
BANCORPSOUTH INS S	SERVICES INC		SSEN LN # 440 N ROGUE, LA 70809			
(b) Amount of sales a	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code	
	3979				3	

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
	,	.,,				
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
( ) ) !			• • • • • • • • • • • • • • • • • • • •			
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
	T		<u> </u>			
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
	, , , , , , , , , , , , , , , , , , ,					
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
•	, ,					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

		•
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ay		•

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of				
_		this report.				
		nt value of plan's interest under this contract in the general account at year				
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5	
ь		acts With Allocated Funds:				
	а	State the basis of premium rates				
	<b>L</b>	Describeration and the country			Ch	
		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				
	e	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 d	heck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
•				ion guarantee		
	u			.o guarantos		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year	. 7c(1)			
		(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)			
	)					
		(C) Total additions			7c(6)	0
	_	(6)Total additions			76(6)	
		otal of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )	Γ		/u	
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		Administration charge made by carrier	7e(1)			
		3) Transferred to separate account	7e(2)			
	`	4) Other (specify below)	7e(3)			
	(	T) Outor (specify below)	, 5(7)			
	ļ	•				
	(	5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f	

	Schedule A (Form 5500) 2012	Pa	ge <b>4</b>	
rt I	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contracts the entire group of such individual contracts with each carrier may be to	are experience	e-rated as a unit. Where contra	
Ber	nefit and contract type (check all applicable boxes)			
а	Health (other than dental or vision) <b>b</b> Dental	С	Vision	d X Life insurance
е	Temporary disability (accident and sickness) <b>f</b> X Long-term disabili	ty <b>g</b>	Supplemental unemployment	h Prescription drug
i	Stop loss (large deductible) j HMO contract	k	PPO contract	I Indemnity contract
m				
•••				
Ехр	erience-rated contracts:			
a	Premiums: (1) Amount received	. 9a(1)		
	(2) Increase (decrease) in amount due but unpaid	. 9a(2)		
	(3) Increase (decrease) in unearned premium reserve	. 9a(3)		
	(4) Earned ((1) + (2) - (3))		9a(4)	
b	Benefit charges (1) Claims paid	. 9b(1)		
	(2) Increase (decrease) in claim reserves	. 9b(2)		
	(3) Incurred claims (add (1) and (2))			
	(4) Claims charged		9b(4)	
С	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	9c(1)(D)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

143234

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

**10** Nonexperience-rated contracts:

Part III

(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 line 9c(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			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(E)

9c(1)(F)

<sup>12</sup> 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

### **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

2012

Pension Benefit Guaranty Co	rporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection		
For calendar plan year 20°	12 or fiscal pla	an year beginning 01/01/201	2	and en	ding 12	/31/2012	-
A Name of plan HATTIESBURG MEDICAL PARK / CONVA REST GROUP INSURANC			E PLAN		e-digit number (PI	N) <b>•</b>	503
C Plan sponsor's name a HATTIESBURG MEDICAL				<b>D</b> Emplo	-	ation Number	(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							
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or o	contract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
22-2311816	39217	AJS00585-11	4	81	01/01/20	12	01/01/2013
2 Insurance fee and composite descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		0					0
3 Persons receiving com	missions and	fees. (Complete as many entric	es as needed to report all	persons).			
<u> </u>		and address of the agent, broke			ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpose		(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	(4)	<u></u>					
(b) Amount of sales and base Fees and other commissions paid				_			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
	,	.,,				
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
( ) ) !			• • • • • • • • • • • • • • • • • • • •			
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
	T		<u> </u>			
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
	, , , , , , , , , , , , , , , , , , ,					
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
•	, ,					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of				
_		this report.				
		nt value of plan's interest under this contract in the general account at year				
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5	
ь		acts With Allocated Funds:				
	а	State the basis of premium rates				
	<b>L</b>	December 2 and the country			Ch	
		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				
	e	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 d	heck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
•				ion guarantee		
	u			.o guarantos		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year	. 7c(1)			
		(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)			
	)					
		(C) Total additions			7c(6)	0
	_	(6)Total additions			76(6)	
		otal of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )	Γ		/u	
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		Administration charge made by carrier	7e(1)			
		3) Transferred to separate account	7e(2)			
	`	4) Other (specify below)	7e(3)			
	(	T) Outor (specify below)	, 5(7)			
	ļ	•				
	(	5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2012		Page <b>4</b>		
If more than one contract covers the same information may be combined for reporting the entire group of such individual contracts	group of employees of the sam ourposes if such contracts are	experience-rated as a ur	nit. Where contract	
Benefit and contract type (check all applicable boxes	)			
<b>a</b> Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision		<b>d</b> Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	g Supplementa	I unemployment	h Prescription drug
i X Stop loss (large deductible)	j HMO contract	k PPO contract		I  Indemnity contract
m ☐ Other (specify) ▶	<i>•</i> L	Ш		<b>—</b> ,
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpa	id	9a(2)		
(3) Increase (decrease) in unearned premium re	serve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
<b>b</b> Benefit charges (1) Claims paid		9b(1)		
(2) Increase (decrease) in claim reserves		9b(2)		
(3) Incurred claims (add (1) and (2))			· · ·	
(4) Claims charged			9b(4)	
<b>c</b> Remainder of premium: (1) Retention charges	, , , , , , , , , , , , , , , , , , ,			_
(A) Commissions		c(1)(A)		
(B) Administrative service or other fees		c(1)(B)		
(C) Other specific acquisition costs	l <del></del>	c(1)(C)		
(D) Other expenses	90	c(1)(D)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

366003

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

**10** Nonexperience-rated contracts:

Part III

(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 line 9c(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			
<b>11</b> Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(E)

9c(1)(F)

<sup>12</sup> 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

### **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

2012

					rm is Open to Public Inspection				
For calendar plan year 20	12 or fiscal pl	an year beginning 01/01/2012	2	and en	ding 12	/31/2012			
A Name of plan HATTIESBURG MEDICAL	_ PARK / COI	NVA REST GROUP INSURANC	E PLAN		e-digit number (PI	N) •	503		
C Plan sponsor's name as shown on line 2a of Form 5500 HATTIESBURG MEDICAL PARK MANAGEMENT CORP				<b>D</b> Emplo		ation Number	(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		E COMPANY							
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or o	contract year		
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To		
06-0893662	80926	036-7291-00	4	52	01/01/20	12	01/01/2013		
2 Insurance fee and com descending order of the		mation. Enter the total fees and t	otal commissions paid. L	ist in line 3 t	the agents,	brokers, and	other persons in		
(a) Total a	amount of cor	nmissions paid		<b>(b)</b> To	tal amount	of fees paid			
		16148				-	0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	nersons)					
• I diddle receiving com		and address of the agent, broke			ons or fees	were paid			
BANCORPSOUTH INS S		C P.C	D. BOX 250 LFPORT, MS 39501						
			ees and other commissio	ne naid					
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose	<u> </u>	(e) Organization code			
	16148	(c) / unicum		(w) : a.pooc			3		
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid			
		<i>y</i> ,	,						
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid					
commissions pa		(c) Amount		(d) Purpose	)		(e) Organization code		

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid				
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
( ) ) !			• • • • • • • • • • • • • • • • • • • •				
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid				
	T		<u> </u>				
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid				
	, , , , , , , , , , , , , , , , , , ,						
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
•	, ,						
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

		•
חבי	Δ	- 5
ay		•

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for					as a unit for purposes of	
_		this report.				
		nt value of plan's interest under this contract in the general account at year				
_		nt value of plan's interest under this contract in separate accounts at year e	nd		5	
ь		acts With Allocated Funds:				
	а	State the basis of premium rates				
	<b>L</b>	December 2 and the country			Ch	
		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				
	e	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 d	heck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma				
•				ion guarantee		
	u			.o guarantos		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year	. 7c(1)			
		(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)			
	)					
		(C) Total additions			7c(6)	0
	_	(6)Total additions			76(6)	
		otal of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )	Γ		/u	
		Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		Administration charge made by carrier	7e(1)			
		3) Transferred to separate account	7e(2)			
	`	4) Other (specify below)	7e(3)			
	(	T) Outor (specify below)	, 5(7)			
	ļ	•				
	(	5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			7f	

Schedule A (Form 5500) 2012		Page <b>4</b>		
If more than one contract covers the same information may be combined for reporting the entire group of such individual contracts	group of employees of the sar purposes if such contracts are	e experience-rated as a	unit. Where contract	
Benefit and contract type (check all applicable boxe	s)			
a ☐ Health (other than dental or vision)	<b>b</b> X Dental	<b>C</b> Vision		<b>d</b> Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	g Supplement	al unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k ☐ PPO contra		I Indemnity contract
m ☐ Other (specify) ▶	<i>,</i> ¬			
III Carlot (opcomy) /				
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpa	aid	9a(2)		
(3) Increase (decrease) in unearned premium re	eserve	9a(3)		
(4) Earned ((1) + (2) - (3))	<u></u>	······	9a(4)	
<b>b</b> 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)	
<b>c</b> Remainder of premium: (1) Retention charges	`	•		
(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		9c(1)(D)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

143576

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

**10** Nonexperience-rated contracts:

Part III

(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 line 9c(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)(E)

9c(1)(F)

<sup>12</sup> 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

2012

This Form is Open to Public Inspection.

or calendar plan year 2012 or fiscal plan year beginning 01/01/2012	and ending 12/31/201	
A Name of plan	<b>B</b> Three-digit	503
HATTIESBÜRG MEDICAL PARK / CONVA REST GROUP INSURANCE PLAN	plan number (PN)	303
C Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification N	lumber (FIN)
HATTIESBURG MEDICAL PARK MANAGEMENT CORP	64-0604714	(2.11)
	04 0004714	
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 connection plan during the plan year. If a person received <b>only</b> eligible indirect compensation for we answer line 1 but are not required to include that person when completing the remainder	ction with services rendered to the hich the plan received the required	plan or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compension	sation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder		only eligible
indirect compensation for which the plan received the required disclosures (see instruction	ons for definitions and conditions)	Yes X No
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person provereceived only eligible indirect compensation. Complete as many entries as needed (see	• .	ne service providers who
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or address of person who provided yo	u disclosure on eligible indirect con	npensation
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect co	mpensation
, , , , , , , , , , , , , , , , , , , ,	3	•
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect co	mpensation

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

Page <b>3</b> -	1	

answered	d "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	total compensation
			(a) Enter name and FIN or	address (see instructions)		
UNITED H	EALTHCARE SERVIC		9900 BRE	EN ROAD MN008-T390 DNKA, MN 55343		
41-128924	5					
(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?
12 49	CLAIMS PROCESSOR	263124	Yes X No	Yes No 🗓	0	Yes X No
		(	(a) Enter name and EIN or	address (see instructions)		
72-138199	SOUTH INS SERVICE	ES, INC.	P.O. BO) GULFPO	X 250 IRT, MS 39502-0250		
(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?
55	BROKER	0	Yes X No	Yes No 🗵	20751	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?	(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

Page	3	-	2
<sup>2</sup> age	3	-	2

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

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

Page <b>5-</b>
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[					
Part II Service Providers Who Fail or Refuse to Provide Information					
4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			

Page	6-
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Pa	rt III	Termination Information on Accountants and Enrolled Actuaries (see ins	structions)
а	Name:	(complete as many entries as needed)	<b>b</b> EIN:
C	Positio		B EIIV.
d	Addres		<b>e</b> Telephone:
•	/ ladio		С госраново.
Ex	olanatio	):	
			I
<u>a</u>	Name:		b EIN:
d d	Position Address		e Telephone:
u	Addies	.5.	е тетернопе.
Ex	olanatio	n:	
а	Name:		<b>b</b> EIN:
<u>C</u>	Positio		
d	Addres	SS:	e Telephone:
Exi	olanatio		
а	Name:		<b>b</b> EIN:
С	Positio	n:	
d	Addres	ss:	<b>e</b> Telephone:
Evi	olanatio	<u> </u>	
ᄓ	piariatio	i.	
а	Name:		<b>b</b> EIN:
C	Positio		
d	Addres		e Telephone:
Ex	olanatio	1:	

# Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110 1210 - 0089

2012

This Form is Open to **Public Inspection** 

Part I Annual Report Identification Inf			
For calendar plan year 2012 or fiscal plan year begini	ning $01/01/2$		
A This return/report is for:    a multiemployer place   X   a single-employer place   X		[]	ultiple-employer plan; or E (specify)
B This return/report is:  the first return/report an amended return	n/report;	r-1	final return/report; ort plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here	······	П	T she DD/C programs
D Check box if filing under: Form 5558; special extension (		auto	matic extension;
Part II Basic Plan Information - enter all r	equested Information		dt. Thursdish
1a Name of plan HATTIESBURG MEDICAL PARK / CO GROUP INSURANCE PLAN	ONVA REST		1b Three-digit plan number (PN) ► 503  1c Effective date of plan
GROUP INSURANCE I DAM			01/01/1994
2a Plan sponsor's name and address, include room or suite n	umber (employer, if for a	single-employer plan)	2b Employer Identification Number (EIN) 64-0604714
HATTIESBURG MEDICAL PARK MAN	AGEMENT COR	P	2c Sponsor's telephone number (601)583-3232
100 WEST PINE STREET			2d Business code (see instructions) 623000
HATTIESBURG MS 100 WEST PINE STREET	39401		
	39401		
Caution: A penalty for the late or incomplete filing of t			
Under penalties of perjury and other penalties set forth in the instructions, I as the electronic version of this return/report, and to the best of my knowled	declare that I have examined t ige and belief, it is true, correc	his return/report, including acco t, and complete.	mpanying schedules, statements and attachments, as well
SIGN STUPLY SORUL	7/12/13	STEPHEN A.	
Signature of plan administrator	Date/	Enter name of individu	al signing as plan administrator
sign			
HERE Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor
SIGN			
HERE Signature of DFE	Date	Enter name of individu	ıal signing as DFE
Preparer's name (including firm name, if applicable) and	address; include roon	n or suite number. (optic	onal) Preparer's telephone number (optional)
J. FRANK BETTS, CPA			(601)987-4300
EUBANK, BETTS, HIRN, WOOD,	PLTC		
JACKSON MS 3	9211		
For Paperwork Reduction Act Notice and OMB Contr	ol Numbers, see the i	nstructions for Form 5	500. Form 5500 (2012) v. 120126

For	n 5500 (2012)	F	age 2			
3a	Plan administrator's name and address 🗵 Same as Plan Sponsor Name 🗵 Same	3b Administrator's EIN				
			3c Administ	rator's	telephone numb	oer
4	If the name and/or EIN of the plan sponsor has changed since the last ret EIN and the plan number from the last return/report:	urn/report filed for this pl	an, enter the nai	me,	4b EIN	
а	Sponsor's name				4c PN	
5	Total number of participants at the beginning of the plan year			5		444
6	Number of participants as of the end of the plan year (welfare plans compactive participants			6a		481
	Retired or separated participants receiving benefits			6b		
	Other retired or separated participants entitled to future benefits			6c		403
d	Subtotal. Add lines 6a, 6b, and 6c			6d		481
e	Deceased participants whose beneficiaries are receiving or are entitled to			6e 6f		
g	Total. Add lines 6d and 6e  Number of participants with account balances as of the end of the plan ye complete this item)	ear (only defined contribu	tion plans	6g		
h	Number of participants that terminated employment during the plan year	with accrued benefits tha	t were less than			
_	100% yested			6h		
7	Enter the total number of employers obligated to contribute to the plan (o complete this item)			7		,
8a	If the plan provides pension benefits, enter the applicable pension feature	e codes from the List of P	lan Characterist	ics Cod	les in the instruc	otions:
b 4A	If the plan provides welfare benefits, enter the applicable welfare feature ( $4B4D4H$	codes from the List of Pla	n Characteristic	s Code	s in the instructi	ions:
9a	Plan funding arrangement (check all that apply)	b Plan benefit arranger	nent (check all t	hat app	ly)	
	(1) Insurance	(1) Insurance	440(1/0):			
	(2) Code section 412(e)(3) insurance contracts	(2) Code secti	on 412(e)(3) inst	urance (	contracts	
	(3) Trust (4) X General assets of the sponsor	· · · • • • • • • • • • • • • • • • • •	sets of the spon	sor		
10					ber attached.	•
a	Pension Schedules	b General Schedules				
	(1) R (Retirement Plan Information)	(1) H	(Financial Inf			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)   I (3) X 3 A	(Financial Int (Insurance In		on · Small Plan)	
	Purchase Plan Actuarial Information) · signed by the plan actuary	(4) X C	(Service Pro		· ·	
	(3) SB (Single Employer Defined Benefit Plan Actuarial	(5) D	•		lan Information)	
	Information) - signed by the plan actuary	(6) G	(Financial Tra	ansactio	on Schedules)	<del></del>