Form 5500		Annual Return/Report of Employee Benefit Plan			OMB Nos. 1210-0110 1210-0089			
Department of the	Treasury				nefit plans under sections 104 curity Act of 1974 (ERISA) an			
Internal Revenue	Service				ernal Revenue Code (the Code		2013	
Department of Employee Benefit	s Security		Complete all entr					
Administra Pension Benefit Guara			the instructions	is to the Fo	rm 5500.	This	Form is Open to Pu Inspection	ıblic
Part I Annua	I Report Ider	ntification In	formation					
For calendar plan yea	ar 2013 or fiscal	plan year begin	ning 01/01/2013		and ending 12	31/2013		
A This return/report	is for:	a multi	employer plan;	an	nultiple-employer plan; or			
		🗙 a single	e-employer plan;	a D	FE (specify)			
		☐ the fire	t raturn/rapart:	∏ tha	final ratura/rapart:			
<b>B</b> This return/report	IS:	the first return/report; the final return/report;						
		an ame	ended return/report;	as	hort plan year return/report (le	ss than 12 m	nonths).	
C If the plan is a col	lectively-bargain	ed plan, check ł	here				. •	
D Check box if filing	under:	Form 5	5558;	aut	omatic extension;	th th	e DFVC program;	
		special	l extension (enter descript	otion)				
Part II Basi	c Plan Inforr	nation—enter	all requested information	n				
<b>1a</b> Name of plan HATTIESBURG MEE	DICAL PARK / C	ONVA REST G	ROUP INSURANCE PLAI	AN		1k	Three-digit plan number (PN) ▶	503
						10	Effective date of pl 01/01/1994	an
<b>2a</b> Plan sponsor's n HATTIESBURG MEI			or suite number (employe	ver, if for a s	ingle-employer plan)	21	Employer Identifica Number (EIN) 64-0604714	ition
					_	20	Sponsor's telephor number 601-583-3232	
100 WEST PINE STF HATTIESBURG, MS			100 WEST PIN HATTIESBUR			20	Business code (see instructions) 623000	3

## Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	Data		
	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				
HERE	Signature of DFE	Date	Enter name of individu	al signing as DFE
•	's name (including firm name, if applicable) and address; include r	oom or suite number	r. (optional)	Preparer's telephone number (optional) 601-948-2924
HADDO	X REID EUBANK BETTS PLLC			001 340 2324
	T CAPITOL STREET, STE 500 N, MS 39201			

	Form 5500 (2013) Page <b>2</b>		
3a	Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address	<b>3b</b> Ac	Iministrator's EIN
			ministrator's telephone Imber
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	<b>4b</b> E	Ν
а	Sponsor's name	<b>4c</b> PI	N
5	Total number of participants at the beginning of the plan year	5	481
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
а	Active participants	6a	502
b	Retired or separated participants receiving benefits	6b	
C	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a, 6b, and 6c	6d	502
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f	Total. Add lines 6d and 6e.	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

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

9a	a Plan funding arrangement (check all that apply)			<b>9b</b> Plan benefit arrangement (check all that apply)			
	(1)		Insurance		(1)		Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Trust
	(4)	X	General assets of the sponsor		(4)	Х	General assets of the sponsor
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	ed, and, wh	her	re indicated, enter the number attached. (See instructions)
а	a Pension Schedules			b General Schedules			
	(1)		R (Retirement Plan Information)		(1)		H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)		I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	Х	5 A (Insurance Information)
			actuary		(4)	Х	C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)		<b>D</b> (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)		<b>G</b> (Financial Transaction Schedules)

SCHEDULE A	<b>A</b>	Insuranc	ce Information	n		0	MB No. 1210-0110
(Form 5500)		This school up is accurate to be filed up down continue 404 of the					
Department of the Treasury Internal Revenue Service		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2013
Department of Labor Employee Benefits Security Adminis	istration	File as an attachment to Form 5500.					
Pension Benefit Guaranty Corpor	ration	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 2013	or fiscal plan	year beginning 01/01/2013		and en	ding 12	/31/2013	
A Name of plan HATTIESBURG MEDICAL P	ARK / CONV	A REST GROUP INSURANCE F	PLAN		e-digit number (Pl	N) 🕨	503
C Plan sponsor's name as s HATTIESBURG MEDICAL PA				D Emplo 64-060	-	ation Number	· (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance carrie		CANADA					
			(e) Approximate nu	umber of		Policy or	contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	<b>(g)</b> ⊤o
38-1082080 80	0802	227420	428		01/01/20	13	12/31/2013
2 Insurance fee and commis descending order of the an		tion. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total amo	ount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		10211					0
3 Persons receiving commis	ssions and fe	es. (Complete as many entries a	as needed to report all	persons).			
BANCORPSOUTH INS SER		nd address of the agent, broker, o	or other person to who OX 1976	m commiss	ions or fees	were paid	
BANGORI SOUTHING SER			ESBURG, MS 39403				
(b) Amount of sales and b	base		s and other commission				_
commissions paid	10211	(c) Amount		(d) Purpos	9		(e) Organization code
	10211						5
	(a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
	.	Fee	s and other commission	ns paid			
(b) Amount of sales and t commissions paid	base	(c) Amount		(d) Purpos	9		(e) Organization code

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

3

### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid			

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
			<u> </u>	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Part I	I Investment and Annuity Contract Information			
i art i	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier ma	ay be treated as a unit fo	or purposes of
1 0	this report.			
_	rent value of plan's interest under this contract in the general account at year		_	
-	rent value of plan's interest under this contract in separate accounts at year e	end	5	
	tracts With Allocated Funds: State the basis of premium rates			
а				
b	Premiums paid to carrier		6b	
c	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in co			
	retention of the contract or policy, enter amount.	•	<b>6d</b>	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma			
а		ate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		<b>7b</b>	
c	Additions: (1) Contributions deposited during the year	. 7c(1)		
	(2) Dividends and credits	7.(0)		
	(3) Interest credited during the year	= (0)		
	(4) Transferred from separate account			
	(5) Other (specify below)	7.(5)		
	▶			
	(6)Total additions		7c(6)	
d	Total of balance and additions (add lines 7b and 7c(6)).			
е	Deductions:			
	(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			
	(4) Other (specify below)			
	•			
	(5) Total deductions			
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ad	е	4

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gro					
		information may be combined for reporting put the entire group of such individual contracts w	rposes if such co //th each carrier r	ontracts are experiend	ce-rated as a unit. W	/here contract	ts cover individual employees,
8	Bon	efit and contract type (check all applicable boxes)					
U	F		<b>b</b> 🔽 Dentel	<b>م</b> ۲	Vision		
	a	Health (other than dental or vision)	<b>b</b> X Dental	c			<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term	disability <b>g</b>	Supplemental uner	mployment	<b>h</b> Prescription drug
	i [	Stop loss (large deductible)	j HMO cont	ract <b>k</b>	PPO contract		I Indemnity contract
	m	Other (specify)					
	-	_					
9	Expe	erience-rated contracts:					
	a	Premiums: (1) Amount received					
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res	erve				
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basi				_
		(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					_
		(G) Other retention charges					
		(H) Total retention					
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	credited.)	··· 9c(2)	
	d	Status of policyholder reserves at end of year: (1)		•			
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount	entered in line 9c(2)	.)	9e	
10	No	nexperience-rated contracts:				<b></b>	
	а	Total premiums or subscription charges paid to ca				<b>10a</b>	102373
	b	If the carrier, service, or other organization incurr				401	
	retention of the contract or policy, other than reported in Part I, line 2 above, report amount					10b	1

Specify nature of costs 🕨

Part IV Provision of Information

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11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuran	ce Information	n		0	MB No. 1210-0110	
(Form 5500	))							
Department of the Trea Internal Revenue Serv	Department of the Treasury         This schedule is required to be filed under section 104 of the           Internal Revenue Service         Employee Retirement Income Security Act of 1974 (ERISA).					2013		
Department of Labo Employee Benefits Security Ac								
Pension Benefit Guaranty Co	Incurance companies are required to provide the intermation					rm is Open to Public Inspection		
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and er	nding 12	/31/2013	1	
A Name of plan HATTIESBURG MEDICA	VA REST GROUP INSURANCE	PLAN		e-digit number (Pl	N) 🕨	503		
C Plan sponsor's name a HATTIESBURG MEDICA				D Emplo		ation Number	(EIN)	
		ning Insurance Contract ( Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca								
SUN LIFE AND HEALTH	INSURANCE	COMPANY				Dellassa		
(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	contract year (g) To	
06-0893662	80926	036-7291-00	4	457 01/01/20		)13	05/01/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in	
(a) Total	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid		
		3913					0	
3 Persons receiving com		ees. (Complete as many entries	•	• •				
BANCORPSOUTH INS S		and address of the agent, broker,	or other person to who SOX 250	m commiss	sions or fees	were paid		
BANCORFSOUTHINS			PORT, MS 39501					
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			_	
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code	
	3913						3	
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid	1	
		Foo	s and other commission	ns naid				
(b) Amount of sales a commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	

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

### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid		(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	- (e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Part I	I Investment and Annuity Contract Information			
i art i	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier ma	ay be treated as a unit fo	or purposes of
1 0	this report.			
_	rent value of plan's interest under this contract in the general account at year		_	
-	rent value of plan's interest under this contract in separate accounts at year e	end	5	
	tracts With Allocated Funds: State the basis of premium rates			
а				
b	Premiums paid to carrier		6b	
c	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in co			
	retention of the contract or policy, enter amount.	•	<b>6d</b>	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here 🕨 🗌		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma			
а		ate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		<b>7b</b>	
c	Additions: (1) Contributions deposited during the year	. 7c(1)		
	(2) Dividends and credits	7.(0)		
	(3) Interest credited during the year	= (0)		
	(4) Transferred from separate account			
	(5) Other (specify below)	7.(5)		
	▶			
	(6)Total additions		7c(6)	
d	Total of balance and additions (add lines 7b and 7c(6)).			
е	Deductions:			
	(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			
	(4) Other (specify below)			
	•			
	(5) Total deductions			
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ad	е	4

Pa	art II	Welfare Benefit Contract Informat	on				
		If more than one contract covers the same gro					
		information may be combined for reporting put the entire group of such individual contracts w	rposes if such co ith each carrier	ontracts are experier	nce-rated as a un	nit. Where contrac	cts cover individual employees,
8	Bon	efit and contract type (check all applicable boxes)					
U	F			c.	Vision		
	a	Health (other than dental or vision)	<b>b</b> X Dental	С			<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term	n disability <b>g</b>	Supplementa	I unemployment	<b>h</b> Prescription drug
	i [	Stop loss (large deductible)	j HMO cont	tract <b>k</b>	PPO contract	t	I X Indemnity contract
	m	Other (specify)					
	-	_					
9	Expe	erience-rated contracts:					
	a	Premiums: (1) Amount received					
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res	erve				
		(4) Earned ((1) + (2) - (3))					
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves				-	
		(3) Incurred claims (add (1) and (2))					
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or	n an accrual bas		1		_
		(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					_
		(G) Other retention charges					
		(H) Total retention					)
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	credited.)	······ 9c(2)	
	d	Status of policyholder reserves at end of year: (1)		•			
		(2) Claim reserves					
		(3) Other reserves					
	е	Dividends or retroactive rate refunds due. (Do no	t include amoun	t entered in line 9c(2	<b>2)</b> .)	<b>9e</b>	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca					53587
	b	If the carrier, service, or other organization incurr					
	retention of the contract or policy, other than reported in Part I, line 2 above, report amount					10b	

Specify nature of costs 🕨

Part IV Provision of Information

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11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A	<b>A</b>	Insurance Information			MB No. 1210-0110		
(Form 5500)		<del>.</del>					
Department of the Treasury Internal Revenue Service	,	This schedule is required Employee Retirement Inc					2013
Department of Labor Employee Benefits Security Admini	istration	File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Corpo	oration	<ul> <li>Insurance companies an pursuant to El</li> </ul>	re required to provide to RISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 2013	or fiscal plan	year beginning 01/01/2013		and en	ding 12	/31/2013	
A Name of plan HATTIESBURG MEDICAL P	PARK / CONV	A REST GROUP INSURANCE F	PLAN		e-digit number (Pl	N) 🕨	503
C Plan sponsor's name as s HATTIESBURG MEDICAL P				D Emplo 64-060		ation Numbe	r (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance carrie		CANADA					
			(e) Approximate nu	umber of		Policy or	contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	(g) To
38-1082080 80	0802	010829	51	17	01/01/20	13	12/31/2013
2 Insurance fee and commis descending order of the an		tion. Enter the total fees and tota	I commissions paid. Li	ist in line 3	the agents,	brokers, and	other persons in
(a) Total am	ount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		13124					0
3 Persons receiving commis	ssions and fe	es. (Complete as many entries a	as needed to report all	persons).			
BANCORPSOUTH INS SER			or other person to whor OX 250 PORT, MS 39502	m commiss	ions or fees	were paid	
		Fee	s and other commissior	ns naid			
(b) Amount of sales and l commissions paid	base	(c) Amount		(d) Purpos	e		(e) Organization code
	13124						
	(a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(h) Amount of a last of the la	haaa	Fee	s and other commissior	ns paid			
(b) Amount of sales and l commissions paid	udse	(c) Amount		(d) Purpos	е		(e) Organization code

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

### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Part I	I Investment and Annuity Contract Information			
i art i	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier ma	ay be treated as a unit fo	or purposes of
1 0	this report.			
_	rent value of plan's interest under this contract in the general account at year		_	
-	rent value of plan's interest under this contract in separate accounts at year e	end	5	
	tracts With Allocated Funds: State the basis of premium rates			
а				
b	Premiums paid to carrier		6b	
c	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in co			
	retention of the contract or policy, enter amount.	•	<b>6d</b>	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here 🕨 📘		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma			
а		ate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		<b>7b</b>	
c	Additions: (1) Contributions deposited during the year	. 7c(1)		
	(2) Dividends and credits	7.(0)		
	(3) Interest credited during the year	= (0)		
	(4) Transferred from separate account			
	(5) Other (specify below)	7.(5)		
	▶			
	(6)Total additions		7c(6)	
d	Total of balance and additions (add lines 7b and 7c(6)).			
е	Deductions:			
	(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			
	(4) Other (specify below)			
	•			
	(5) Total deductions			
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	age	4

Part II	I Welfare Benefit Contract Informat If more than one contract covers the same guinformation may be combined for reporting puthe entire group of such individual contracts	oup of employees of the s urposes if such contracts	are experienc	e-rated as a unit. Whe	ere contract	
8 Ben	efit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> Life insurance
е	Temporary disability (accident and sickness)	f 🛛 Long-term disabilit	у д	Supplemental unemp	oloyment	h Prescription drug
i [	Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify)					
<b>9</b> Expe	erience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid	1	9a(2)			
	(3) Increase (decrease) in unearned premium res	erve	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))				9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (c	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		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)		-	
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	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	l in line <b>9c(2)</b> .	.)	9e	
<b>10</b> No	nexperience-rated contracts:					
а	Total premiums or subscription charges paid to c	arrier			10a	131244
b	If the carrier, service, or other organization incurr retention of the contract or policy, other than rep	red any specific costs in c	onnection wit	h the acquisition or	10b	

Specify nature of costs

Part IV	Provision of Information			
<b>11</b> Did 1	ne insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
<b>12</b> If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A		Insurance Information			MB No. 1210-0110		
(Form 5500)		This schedule is required	to be filed under section	on 101 of th			2013
Department of the Treasury Internal Revenue Service		Employee Retirement Inc					2013
Department of Labor Employee Benefits Security Adminis	istration	File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Corpor	ration	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 2013	or fiscal plan	year beginning 01/01/2013		and er	ding 12	/31/2013	
A Name of plan HATTIESBURG MEDICAL P	ARK / CONV	A REST GROUP INSURANCE	PLAN		e-digit number (Pl	N) 🕨	503
C Plan sponsor's name as s HATTIESBURG MEDICAL P/				D Emplo 64-060		ation Number	r (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance carrie		CANADA					
SUN LIFE ASSURANCE CC		CANADA	(e) Approximate nu	imbor of		Policy or	contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To
38-1082080 80	0802	010829	51	19	01/01/20	13	12/31/2013
2 Insurance fee and commis descending order of the am		tion. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total amo	ount of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		2361					0
3 Persons receiving commis	ssions and fe	es. (Complete as many entries	as needed to report all	persons).			
BANCORPSOUTH INS SER			or other person to who 3OX 250 PORT, MS 39502	m commiss	ions or fees	were paid	
		Faa	a and other commission				
(b) Amount of sales and b commissions paid	base	(c) Amount	s and other commission	(d) Purpos	e		(e) Organization code
· · ·	2361						
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(h) Amount of color and h	haaa	Fee	s and other commission	ns paid			
(b) Amount of sales and b commissions paid	uase	(c) Amount		(d) Purpos	е		(e) Organization code

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

### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization code		
commissions paid				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Part I	I Investment and Annuity Contract Information			
i art i	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier ma	ay be treated as a unit fo	or purposes of
1 0	this report.			
_	rent value of plan's interest under this contract in the general account at year		_	
-	rent value of plan's interest under this contract in separate accounts at year e	end	5	
	tracts With Allocated Funds: State the basis of premium rates			
а				
b	Premiums paid to carrier		6b	
c	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in co			
	retention of the contract or policy, enter amount.	•	<b>6d</b>	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here 🕨 🗌		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma			
а		ate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		<b>7b</b>	
c	Additions: (1) Contributions deposited during the year	. 7c(1)		
	(2) Dividends and credits	7.(0)		
	(3) Interest credited during the year	= (0)		
	(4) Transferred from separate account			
	(5) Other (specify below)	7.(5)		
	▶			
	(6)Total additions		7c(6)	
d	Total of balance and additions (add lines 7b and 7c(6)).			
е	Deductions:			
	(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			
	(4) Other (specify below)			
	•			
	(5) Total deductions			
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pag	e <b>4</b>

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts					is cover maividual employees,
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d 🛛 Life insurance
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	y <b>g</b>	Supplemental unemp		<b>h</b> Prescription drug
	i [		j HMO contract	י, ש_ k	PPO contract	Joymon	
		Stop loss (large deductible)		n _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Evne	rience-rated contracts:					
J		Premiums: (1) Amount received	]	9a(1)			4
		(2) Increase (decrease) in amount due but unpaid					-
		(3) Increase (decrease) in unearned premium res		9a(3)			1
		(4) Earned ((1) + (2) - (3))	L			9a(4)	
	-	Benefit charges (1) Claims paid	Γ				
		(2) Increase (decrease) in claim reserves					7
		(3) Incurred claims (add (1) and (2))	L			9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)		•		
		(A) Commissions		9c(1)(A)			7
		(B) Administrative service or other fees		9c(1)(B)			7
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide I	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	l in line <b>9c(2)</b> .	.)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	23611
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

Specify nature of costs

-

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	Х	No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDUL	EA	Insuranc	ce Information	n		OM	IB No. 1210-0110
(Form 550 Department of the Tre		This schedule is required	to be filed under section	on 104 of th	e		2013
Internal Revenue Se	ervice	Employee Retirement Inc					2010
Employee Benefits Security A	Administration	File as an a	ttachment to Form 55	00.		This For	m is Open to Public
Pension Benefit Guaranty	Corporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide to RISA section 103(a)(2)		ion	This For	Inspection
For calendar plan year 2	013 or fiscal plar	year beginning 01/01/2013		and en	ding 12	2/31/2013	1
A Name of plan HATTIESBURG MEDICA	AL PARK / CON	A REST GROUP INSURANCE	PLAN		e-digit number (Pl	N)	503
C Plan sponsor's name as shown on line 2a of Form 5500       D Employer Identification Num         HATTIESBURG MEDICAL PARK MANAGEMENT CORP       64-0604714					cation Number	(EIN)	
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information	:						
(a) Name of insurance of SUN LIFE ASSURANC		CANADA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
38-1082080	80802	225943	502 01/01/2013		)13	12/31/2013	
2 Insurance fee and con descending order of the		ation. Enter the total fees and tota	I commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
<b>(a)</b> Tota	I amount of comr	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		0					0
3 Persons receiving co	mmissions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,	or other person to whor OX 1976	m commiss	ions or fees	s were paid	
BANCORPSOUTH INS	SERVICES INC		IESBURG, MS 39403				
(b) Amount of sales			s and other commissior				
commissions p	aid 0	(c) Amount		(d) Purpos	e		(e) Organization code
	U						5
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	s were paid	1
		Fee	s and other commissior	ns paid			
(b) Amount of sales	and base						(a) Organization and

commissions paid	(c) Amount	(d) Purpose		(e) Organization code
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Schedule A (Form 550				ule A (Form 5500) 2013

v. 130118

### (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization code		
commissions paid				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	
			<u> </u>	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Page 3

Part I	I Investment and Annuity Contract Information			
i art i	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier ma	ay be treated as a unit fo	or purposes of
1 0	this report.			
_	rent value of plan's interest under this contract in the general account at year		_	
-	rent value of plan's interest under this contract in separate accounts at year e	end	5	
	tracts With Allocated Funds: State the basis of premium rates			
а				
b	Premiums paid to carrier		6b	
c	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in co			
	retention of the contract or policy, enter amount.	•	<b>6d</b>	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here 🕨 🗌		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma			
а		ate participation guarantee		
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year		<b>7b</b>	
c	Additions: (1) Contributions deposited during the year	. 7c(1)		
	(2) Dividends and credits	7.(0)		
	(3) Interest credited during the year	= (0)		
	(4) Transferred from separate account			
	(5) Other (specify below)	7.(5)		
	▶			
	(6)Total additions		7c(6)	
d	Total of balance and additions (add lines 7b and 7c(6)).			
е	Deductions:			
	(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			
	(4) Other (specify below)			
	•			
	(5) Total deductions			
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pag	e <b>4</b>

Part I						
	If more than one contract covers the same g information may be combined for reporting p					
	the entire group of such individual contracts					
8 Ben	efit and contract type (check all applicable boxes)	)				
а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	ployment	<b>h</b> Prescription drug
i	Stop loss (large deductible)	j 🗍 HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify)			-		
[						
9 Expe	erience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			]
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			]
	(3) Increase (decrease) in unearned premium res	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))					
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)	
С	Remainder of premium: (1) Retention charges (	on an accrual basis)				_
	(A) Commissions		9c(1)(A)			_
	(B) Administrative service or other fees					
	(C) Other specific acquisition costs					_
	(D) Other expenses		-			_
	(E) Taxes					-
	(F) Charges for risks or other contingencies.					-
	(G) Other retention charges		9c(1)(G)		1	
	(H) Total retention	_			9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were paid ir	n cash, or	credited.)		
d	Status of policyholder reserves at end of year: (*	I) Amount held to provide	benefits after	r retirement	9d(1)	
	(2) Claim reserves				. 9d(2)	
	(3) Other reserves					
е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2)</b>	.)	<b>9e</b>	
<b>10</b> No	nexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier			<b>10a</b>	317253
b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b	

Specify nature of costs

Part IV	Provision of Information			
<b>11</b> Did	he insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
<b>12</b> If the	e answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE C	SCHEDULE C Service Provider Information			OMB No. 1210-0110
(Form 5500)				2013
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under s Retirement Income Security Act			
Department of Labor Employee Benefits Security Administration	File as an attachment to	o Form 5500.	This F	Form is Open to Public Inspection.
Pension Benefit Guaranty Corporation For calendar plan year 2013 or fiscal pla		and ending 12/3	1/0040	
A Name of plan		<b>B</b> Three-digit	1/2013	
	NVA REST GROUP INSURANCE PLAN	plan number (PN)	•	503
C Plan sponsor's name as shown on li HATTIESBURG MEDICAL PARK MAN	D Employer Identification Number (EIN) 64-0604714			
Part I Service Provider Info	ormation (see instructions)			
<ul> <li>a Check "Yes" or "No" to indicate wheth indirect compensation for which the p</li> <li>b If you answered line 1a "Yes," enter received only eligible indirect compensation</li> </ul>	<b>ceiving Only Eligible Indirect Compe</b> her you are excluding a person from the remaind olan received the required disclosures (see instru- r the name and EIN or address of each person p insation. Complete as many entries as needed (s imme and EIN or address of person who provided	er of this Part because they rece ictions for definitions and condition roviding the required disclosures see instructions).	for the serv	∐Yes ⊠No ice providers who
(b) Enter na	ame and EIN or address of person who provided	you disclosure on eligible indirec	t compensa	tion
(b) Enter na	me and EIN or address of person who provided	you disclosures on eligible indired	ct compensa	ation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

	(a) Enter name and EIN or address (see instructions)						
UNITED H	EALTHCARE SERVIC	ES, INC.		EN ROAD MN008-T390 DNKA, MN 55343			
41-128924	5						
<b>(b)</b> Service Code(s)	(c) 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	<b>(e)</b> 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?	
12 49	CLAIMS PROCESSOR	283653	Yes 🛛 No 🗌	Yes 🗌 No 🕅	0	Yes 🛛 No 🗌	
		(	<b>a)</b> Enter name and EIN or	address (see instructions)			
BANCORP	SOUTH INS SERVICE	ES, INC.	P.O. BO GULFPC	X 250 DRT, MS 39502-0250			
72-138199	7						
<b>(b)</b> Service Code(s)	(c) 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?	
55	BROKER	0	Yes 📈 No 🗌	Yes 🗌 No 🛛	20079	Yes 🗌 No 🗙	
		(	<b>a)</b> Enter name and EIN or	address (see instructions)	L		
<b>(b)</b> Service Code(s)	(c) 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
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

	(a) Enter name and EIN or address (see instructions)					
<b>(b)</b> Service Code(s)	(C) 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 🗌
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(C) 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 🗌
		(	a) Enter name and EIN or	address (see instructions)		
<b>(b)</b> Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗍	Yes 🗌 No 🗌		Yes 🗌 No 🗍

# Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
		compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any
	formula used to determine t	the service provider's eligibility le indirect compensation.
(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	(e) Describe the indirect c	ompensation, including any the service provider's eligibility
	for or the amount of th	ie indirect compensation.
(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	(e) Describe the indirect conformula used to determine to	he service provider's eligibility
	for or the amount of th	e indirect compensation.

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F	Part II	Service Providers Who Fail or Refuse to	Provide Infor	mation			
4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to co this Schedule.							
	<b>(a)</b> Ent	er 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			
	<b>(a)</b> Ent	er 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			
	<b>(a)</b> Ent	er 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) Ent	er 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			
	<b>(a)</b> Ent	er 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			
	<b>(a)</b> Ent	er 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			

Part III		Termination Information on Accountants and Enrolled Actuaries (see in (complete as many entries as needed)	structions)			
а	Name		<b>b</b> EIN:			
C Position:						
<b>d</b> Addr		3S:	e Telephone:			
Explanation:						

Name:	<b>b</b> EIN:		
Position:			
Address:	e Telephone:		
	Position:		

Explanation:

а	Name:	<b>b</b> EIN:		
С	Position:			
d	Address:	e Telephone:		

Explanation:

а	Name:	<b>b</b> EIN:		
С	Position:			
d	Address:	e Telephone:		

Explanation:

а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

Form 5500		eturn/Report of E			OMB Nos. 1210 - 0110 1210 - 0089		
Department of the Treasury Internal Revenue Service	This form is required and 4065 of the Emp						
Department of Labor		57(b), and 6058(a) of th		2013			
Employee Benefits Security Administration Pension Benefit Guaranty Corporation		Complete all entries i the instructions to	th	This Form is Open to			
Part I Annual Repo	rt Identification Inf	ormation			Public Inspection		
For calendar plan year 2013			2013 and	lending 12/	31/2013		
A This return/report is for:	a multiemployer pla	· · · · ·		a multiple-employer			
	X a single-employer p	blan;		a DFE (specify)			
<b>B</b> This return/report is:	the first return/repo	<b></b>		the final return/repo	<del></del>		
B This return/report is:	an amended return	-		•	turn/report (less than 12 months)		
C If the plan is a collectively-ba	—				▶		
D Check box if filing under:	Form 5558;			automatic extension	n; the DFVC program;		
Desis Dies in	special extension (						
	formation - enter all re	equested information			·		
1a Name of plan HATTIESBURG MEDI	CAL PARK / CO	ONVA REST		1b Three-d plan nu	ngit mber (PN) ► 503		
GROUP INSURANCE					e date of plan		
2a Plan sponsor's name and addr	ress: include room or suite n	umber (employer, if for a	single-employer pla		) 1 / 1 9 9 4 er Identification Number (EIN)		
·		• • •		64-0	604714		
HATTIESBURG MEDI	CAL PARK MAN	AGEMENT COR	P		or's telephone number		
				(601)58 2d Busines	ss code (see instructions)		
100 WEST PINE ST	REET			6230			
HATTIESBURG		39401					
100 WEST PINE ST	REET						
HATTIESBURG	MS	39401					
Caution: A penalty for the late	or incomplete filing of t	his return/report will	be assessed uni	ess reasonable caus	e is established.		
Under penalties of perjury and other penalt as the electronic version of this return/repo				ng accompanying schedules	s, statements and attachments, as well		
SIGN /	E-World	10-3-14	     STEPHEN	A. WORREL			
HERE Signature of plan admi		Date	Enter name of in	dividual signing as pl	an administrator		
SIGN							
HERE Signature of employer	/plan sponsor	Date	Enter name of ir	dividual signing as er	nployer or plan sponsor		
SIGN							
HERE Signature of DFE Date Enter name of individual signing as DFE							
Preparer's name (including firm	name, if applicable) and	address; include room	n or suite number.	(optional) Prepa	rer's telephone number		
				(option	nal)		
J FRANK BETTS,	CPA			60	)1-948-2924		
HADDOX REID EUB		LC					
188 EAST CAPITO	-						
JACKSON	MS 31	9201					
For Paperwork Reduction Act	Notice and OMB Contro	ol Numbers, see the i	nstructions for F	orm 5500.	Form 5500 (2013		

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v. 130118

Forr	n 5500 (2013) 130118 Page				
3a	Plan administrator's name and address 🕱 Same as Plan Sponsor Name 🕱 Same as Plan Sponsor Address 3	b Administrato	ator's EIN ator's telephone number		
	3	C Administrato			
4 a	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, EIN and the plan number from the last return/report: Sponsor's name	enter the name,	ne, <b>4b</b> EIN <b>4c</b> PN		
5	Total number of participants at the beginning of the plan year		5	481	
6 a	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, an Active participants	· –	6a	502	
b	Retired or separated participants receiving benefits		6b		
c d	Other retired or separated participants entitled to future benefits		<u>6c</u> 6d	502	
e f	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		6e 6f		
g	Number of participants with account balances as of the end of the plan year (only defined contribution complete this item)	6g			
h	Number of participants that terminated employment during the plan year with accrued benefits that w 100% vested	ere less than	6h		
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		7		

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

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

9a	Plan funding arrangement (check all that apply)			9b	9b Plan benefit arrangement (check all that apply)				
	(1)	L I	nsurance		(1)		Insuran	се	
	(2)	2) Code section 412(e)(3) insurance contracts			(2) Code section 412(e)(3) insurance contracts				
	(3)	ר 📋	rust		(3) 🗌 Trust				
	(4)	X	General assets of the sponsor		(4)	X	Genera	lasse	ts of the sponsor
10		Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)			tached	l, a	nd, whe	re ind	cated, enter the number attached.
а	Pens	Pension Schedules			b General Schedules				
	(1)	Ц	R (Retirement Plan Information)		(1)			Н	(Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money	,	(2)			I	(Financial Information - Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan	hase Plan Actuarial Information) $\cdot$ signed by the plan (3) 🛛 $5$		5	Α	(Insurance Information)	
		_	actuary		(4)	X		С	(Service Provider Information)
	(3)	Ш	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D	(DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)			G	(Financial Transaction Schedules)

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