Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

	_					inspection		
Part I		entification Information						
For caler	For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014							
A This	eturn/report is for:	a multiemployer plan;		ployer plan (Filers checkir employer information in ac	-		ons); or	
		x a single-employer plan;	a DFE (speci	ify)				
B This r	eturn/report is:	the first return/report;	the final retur	rn/report;				
		an amended return/report;	a short plan	year return/report (less tha	ın 12 month	s).		
C If the	plan is a collectively-bargai	ned plan, check here				▶ □		
	k box if filing under:	X Form 5558;	automatic ext		_			
D Chec	N DOX II IIIIII G UIIGEI.	special extension (enter description		,	□	r o program,		
Part	I Pasia Blan Infor	mation—enter all requested information	,					
	e of plan	mation—enter all requested informa	ation		1h	Three-digit plan		
		CONVA REST GROUP INSURANCE I	PLAN		''	number (PN) ▶	503	
					1c	Effective date of pl	an	
						01/01/1994		
	sponsor's name and addre	ess; include room or suite number (emp ANAGEMENT CORP	oloyer, if for a single-	employer plan)	2b	Employer Identifica Number (EIN) 64-0604714	ation	
100 WES	ST PINE STREET	100 WES	T PINE STREET		2c	2c Plan Sponsor's telephone number 601-583-3232		
HATTIES	SBURG, MS 39401	HATTIESI	BURG, MS 39401		2d	2d Business code (see instructions) 623000		
						020000		
Caution	A penalty for the late or i	incomplete filing of this return/repor	rt will be assessed	unless reasonable caus	e is establi	shed.		
		penalties set forth in the instructions, I as the electronic version of this return						
	•		1	7 0	<u> </u>			
SIGN	Filed with authorized/valid	electronic signature.						
HERE	Signature of plan admin		Date	Enter name of individual signing as plan administrator				
	orginature or plan damin	ionator	Date	Enter name of marviada	i oigiiiig ao	pian administrator		
SIGN								
HERE	Signature of employer/p	lan sponsor	Date	Enter name of individua	l signing as	employer or plan sr	onsor	
	Orginatar o or omproyon, p	ian openios.	Bato	Enter name of marriaga	i oigimig ao	omployor of plant of	7011001	
SIGN								
HERE Signature of DFE Date Enter name of individual signin						DEE		
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)						telephone number		
J FRANK BETTS, CPA (option					(optional)			
HADDOX REID EUBANK BETTS PLLC						601-948-2924		
	T CAPITOL STREET, STE N, MS 39201	500						

Form 5500 (2014) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor	3b Administrator's EIN		
			3c Admir	nistrator's telephone per
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	502
6	Number of participants as of the end of the plan year unless otherwise states 6a(2), 6b, 6c, and 6d).	d (welfare plans complete only lines 6a(1),		
a(′	Total number of active participants at the beginning of the plan year		6a(1)	502
a(2	2) Total number of active participants at the end of the plan year		6a(2)	574
b	Retired or separated participants receiving benefits		. 6b	
С	Other retired or separated participants entitled to future benefits		. 6с	
d	Subtotal. Add lines 6a(2), 6b, and 6c.		. 6d	574
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive 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 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	multiemployer plans complete this item)	. 7	
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits.	des from the List of Plan Characteristics Code	s in the inst	
уа	Plan funding arrangement (check all that apply) (1) Insurance	9b Plan benefit arrangement (check all that (1) Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance o	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 attache	d. (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 Purchase Plan Actuarial Information) - signed by the plan actuary	(2) I (Financial Inform (3) X _4 A (Insurance Inform (4) C (Service Provide	rmation)	,
_	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participation (6) G (Financial Trans	-	
			-	

Form 5500 (2014) Page **3**

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)					
If "Yes" is checke	If "Yes" is checked, complete lines 11b and 11c.				
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)					
Receipt Confirmation Code					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	14 or fiscal pla	an year beginning 01/01/2014	and	ending 12/31/2014			
A Name of plan HATTIESBURG MEDICAL	_ PARK / CON	NVA REST GROUP INSURANCE	E DI AN	ree-digit an 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							
			Coverage, Fees, and Cors a unit in Parts II and III can be re				
1 Coverage Information:							
(a) Name of insurance ca	rrier						
SUN LIFE ASSURANCE	COMPANY C	OF CANADA					
/I-V FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy	or contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
38-1082080	80802	227420	516	01/01/2014	12/31/2014		
2 Insurance fee and com- descending order of the			otal commissions paid. List in line	3 the agents, brokers, a	nd other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
_		16728			0		
3 Persons receiving com			s as needed to report all persons)				
BANCORPSOUTH INSU	. ,	· · · · · · · · · · · · · · · · · · ·	r, or other person to whom commi BOX 1976	issions or fees were paid			
DANOCKI GOOTTINGO	NANOL OLIV		TIESBURG, MS 39403				
(b) Amount of sales ar	nd base	Fe	es and other commissions paid				
commissions pa		(c) Amount	(d) Purpose		(e) Organization code		
16728					3		
	(a) Name	and address of the agent, broke	r, or other person to whom commi	ssions or fees were paid			
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code		

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(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					
	T				
(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 indivithis report.	th each carrier may b	e treate	d as a unit for purposes of	
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.	nnection with the	acquisition or	6d	
		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	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year		•		
		(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)			
		•				
					_ /-:	
		(6)Total additions			7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ C(4)			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Pa	age 4		
experien		ere contract	ployee organizations(s), the ts cover individual employees,
c [g [k [Vision Supplemental unemp PPO contract		d Life insurance h Prescription drug l Indemnity contract
9a(1)			
9a(2) 9a(3)			
		9a(4)	

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	urposes if such contracts a	are experienc	ce-rated as a unit. Wh	nere contract		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b X Dental	c	Vision		d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disabilit	у д	Supplemental unem	ployment	h Prescription dr	rug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity cont	tract
	m	Other (specify)	<i>-</i> L	_	_			
9	Expe	erience-rated contracts:						
_		Premiums: (1) Amount received		9a(1)			-	
		(2) Increase (decrease) in amount due but unpaid	•	9a(2)			1	
		(3) Increase (decrease) in unearned premium res		9a(3)			1	
		(4) Earned ((1) + (2) - (3))	<u> </u>			. 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 (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes		9c(1)(E)			_	
		(F) Charges for risks or other contingencies		9c(1)(F)			_	
		(G) Other retention charges				T =		
		(H) Total retention				. 9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1) Amount held to provide I	benefits after	r retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	I in line 9c(2)	.)	. 9e		
10	No	onexperience-rated contracts:						
	a	Total premiums or subscription charges paid to c				. 10a	 	168639
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				. 10b		
	Sp	pecify 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	X No	_

Schedule A (Form 5500) 2014

Part III Welfare Benefit Contract Information

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)).			
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan HATTIESBURG MEDICAL	L PARK / CON	VA REST GROUP INSURANC	E PLAN	B Three plan	e-digit number (P	(N)	503
C Plan sponsor's name a HATTIESBURG MEDICAL				D Emplo 64-060		cation Number (EIN)
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
SUN LIFE ASSURANCE	COMPANY O	F CANADA					
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)) From	(g) To
38-1082080	80802	010829	39	96	01/01/20	014	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	, brokers, and ot	her persons in
(a) Total a	amount of com	•		(b) To	tal amount	of fees paid	
		11521					0
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	s were paid	
BANCORPSOUTH INS S	SERVICES INC		. BOX 250 .FPORT, MS 39501				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
					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 pa		(c) Amount		(d) Purpose			(e) Organization code
		L.					

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(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					
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts wi	th each carrier may b	e treate	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.	nnection with the	acquisition or	6d	
		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	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year		•		
		(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)			
		•				
					_ /-:	
		(6)Total additions			7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ C(4)			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Page 4	
employer(s) or members of the same en perience-rated as a unit. Where contract as a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d Life insurance h Prescription I Indemnity co

	Schedule A (Form 5500) 2014
Part III	Welfare Benefit Contract Information

ra	rt II	If more than one contract covers the same gi	-	ame employe	ar(s) or mambars of the	same em	nlovee organizations(s)	the
		information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts a	re 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 Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term disability	⁄ g 🗌	Supplemental unemp	loyment	h Prescription drug	
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	t
	m	Other (specify)		<u></u>			_	
_								
9	•	erience-rated contracts:	Г	1				
	а	Premiums: (1) Amount received	F	9a(1)				
		(2) Increase (decrease) in amount due but unpaid	-	9a(2)				
		(3) Increase (decrease) in unearned premium res	<u> </u>					
		(4) Earned ((1) + (2) - (3))	The state of the s			9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves	_					
		(3) Incurred claims (add (1) and (2))			ľ	9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c					_	
		(A) Commissions	F	9c(1)(A)				
		(B) Administrative service or other fees	-	9c(1)(B)			_	
		(C) Other specific acquisition costs	F	9c(1)(C)			_	
		(D) Other expenses	l e	9c(1)(D)			_	
		(E) Taxes	F	9c(1)(E)				
		(F) Charges for risks or other contingencies.	I -	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 b	enefits 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	in line 9c(2).)	9e		
10	No	nexperience-rated contracts:						
	a Total premiums or subscription charges paid to carrier					10a		115212
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	10b					
	Sp	pecify nature of costs			•			

Part IV	Provision of Information			
11 Did t	he 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.

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

2014

This Form is Open to Public

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				Inspection				
For calendar plan year 20	14 or fiscal pl	an year beginning 01/01/2014	ļ	and en	ding 12/3	31/2014		
A Name of plan	•	NVA REST GROUP INSURANCE	E PLAN		e-digit number (PN))	503	
C Plan sponsor's name a HATTIESBURG MEDICAL				D Emplo	•	ation Number	(EIN)	
	on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
(a) Name of insurance ca SUN LIFE ASSURANCE		DF CANADA	(a) Associated as			Dollayor	ontro et vecer	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at policy or contract	end of	(f)	From	(g) To	
38-1082080	80802	010829	39		01/01/201	14	12/31/2014	
2 Insurance fee and composite descending order of the		nation. Enter the total fees and to	otal commissions paid. Lis	st in line 3	the agents, b	orokers, and o	other persons in	
	(a) Total amount of commissions paid (b) Total amount of fees paid							
		1983					0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all p	persons).				
	(a) Name	and address of the agent, broke	r, or other person to whon	n commiss	ions or fees	were paid		
BANCORPSOUTH INS S	SERVICES IN		. BOX 250 LFPORT, MS 39502					
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid				
commissions pa		(c) Amount	(d) Purpose	9		(e) Organization code	
	1983							
	(a) Name	and address of the agent, broke	r or other person to whon	n commiss	ions or fees	were paid		
	(a) Hame	and address of the agont, protect	r, or outer person to when	<u> </u>	10110 01 1000	word paid		
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid				
commissions pa		(c) Amount	(d) Purpose	Э		(e) Organization code	

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts wi	th each carrier may b	e treate	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.	nnection with the	acquisition or	6d	
		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	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year		•		
		(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)			
		•				
					_ /-:	
		(6)Total additions			7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ C(4)			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

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me employer(s) or members of the same employee organizations(s), the e experience-rated as a unit. Where contracts cover individual employees, ated as a unit for purposes of this report.						
Vision Supplemental unemployme PPO contract	o ent h					
9a	(4)					
	er(s) or members of the same ce-rated as a unit. Where con init for purposes of this report Vision Supplemental unemployme PPO contract	er(s) or members of the same emploe-rated as a unit. Where contracts init for purposes of this report. Vision Supplemental unemployment				

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	irposes if such contracts a	re 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 Dental	c	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	, g [Supplemental unemp	loyment	$\mathbf{h} \ \square$ Prescription drug	
	i [Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	t
	m	Other (specify)						
9	Expe	erience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)			_	
		(2) Increase (decrease) in amount due but unpaid					_	
		(3) Increase (decrease) in unearned premium res	- - - - - - - - - -					
		(4) Earned ((1) + (2) - (3))	_			9a(4)		
	_	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))	_			9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs	<u> </u>	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 b	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2) .	.)	9e		
10		nexperience-rated contracts:			,			
	_	Total premiums or subscription charges paid to c				10a		19840
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
	Sp	ecify 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	X No	

Schedule A (Form 5500) 2014

Welfare Benefit Contract Information

Part III

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2014

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					inspection			
For calendar plan year 20°	14 or fiscal pla	n year beginning 01/01/2014		and en	ding 12	2/31/2014		
A Name of plan HATTIESBURG MEDICAL	PARK / CON	VA REST GROUP INSURANCE	E PLAN	B Three plan	e-digit number (P	N) •	503	
	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	rrier							
SUN LIFE ASSURANCE	COMPANY O	F CANADA						
/LV FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From		(g) To	
38-1082080	80802	225943	5	574 01/01/2014		014	12/31/2014	
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	, brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
		0					0	
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).				
		and address of the agent, broke		m commissi	ions or fees	s were paid		
BANCORPSOUTH INS S	ERVICES INC		BOX 1976 TIESBURG, MS 39403					
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pai	d	(c) Amount	(d) Purpose		(e) Organization code			
	(a) Name a	and address of the agent, broke	r. or other person to who	m commissi	ions or fees	s were paid		
	(-)		,			p		
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code	

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(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					
	T				
(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 indivithis report.	th each carrier may b	e treate	d as a unit for purposes of	
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.	nnection with the	acquisition or	6d	
		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	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participation g	uarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year		•		
		(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)			
		•				
					_ /-:	
		(6)Total additions			7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(4)			
		(4) Other (specify below)	/ C(4)			
		•				
					70(F)	
	f	(5) Total deductions			7e(5) 7f	0
	1	balance at the end of the current year (Subtract line re(3) from line rd)			7.1	

Page 4	
employer(s) or members of the same en perience-rated as a unit. Where contract as a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d ☐ Life insurance h ☐ Prescription drug I ☐ Indemnity contract

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	irposes if such contracts a	re experienc	ce-rated as a unit. Whe	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp	oloyment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:						
	a ٰ ı	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	ı	• •				
		(3) Increase (decrease) in unearned premium res	-					
		(4) Earned ((1) + (2) - (3))	_			9a(4)		
		Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees	<u> </u>	9c(1)(B)				
		(C) Other specific acquisition costs	L	9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	L	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 b	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	.)	9e		
10		nexperience-rated contracts:			ı			
		Total premiums or subscription charges paid to c				10a	4	05939
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
	Sp	ecify 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	X No	

Schedule A (Form 5500) 2014

Welfare Benefit Contract Information

Part III

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Service Provider Information

OMB No. 1210-0110

2014

This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014	and ending 12/31/2014	
A Name of plan HATTIESBURG MEDICAL PARK / CONVA REST GROUP INSURANCE PLAN	B Three-digit plan number (PN)	503
	p.a.r.va.n.sor (r.v)	
Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (I	EIN)
HATTIESBURG MEDICAL PARK MANAGEMENT CORP	64-0604714	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information record more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of the	with services rendered to the plan or the plan or the plan received the required disclosu	he person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compensation a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this indirect compensation for which the plan received the required disclosures (see instructions for	s Part because they received only elig	
If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see instruction).	•	e providers who
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensat	tion
(b) Enter name and EIN or address of person who provided you disc	closure on eligible indirect compensati	on
(b) Enter name and EIN or address of person who provided you disc	losures on eligible indirect compensat	ion
(b) Enter name and EIN or address of person who provided you disc	losures on eligible indirect compensat	ion

Schedule C (Form 5500) 2014	Page 2- 1
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2014				
-				Page 3 - 1		
answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensatio ch person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
		(a) Enter name and EIN or	address (see instructions)		
UNITED H	EALTHCARE SERVIC	ES, INC.		REN ROAD MN008-T390 FONKA, MN 55343		
(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?	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	314650	Yes 🗵 No 🗌	Yes No X	0	Yes X No
		(a) Enter name and EIN or	address (see instructions)		
	PSOUTH INS SERVICE	ES, INC.	P.O. BC GULFP	0X 250 ORT, MS 39502-0250		
72-138199	7					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
55	BROKER	0	Yes X No	Yes 📗 No 🗵	21745	Yes No X
		(a) Enter name and EIN or	address (see instructions)	*	
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	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 No

Yes No No

Yes No

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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch 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, 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?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) 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 No	Yes No		Yes No 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?	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 compen or provides contract administrator, consulting, custodial, investment advisory, investment madvestions for (a) each source from whom the service provider received \$1,000 or more in incomprovider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	anagement, broker, or recordkeepin direct compensation and (b) each s	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any 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		compensation, including any
		e the 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	(e) Describe the indirect compensation, including a formula used to determine the service provider's elign for or the amount of the indirect compensation	

Page 5	5-
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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			
(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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_	4 850		
Pa	rt III	Termination Information on Accountants and Enrolled	Actuaries (see instructions)
_	Name:	(complete as many entries as needed)	b EIN:
a c	Positio		D EIIN.
d	Addres		e Telephone:
u	Addres	S.	e releptione.
Fx	planation		
-/-	p		
а	Name:		b EIN:
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d	Addres		e Telephone:
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Ex	planation	:	
а	Name:		b EIN:
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Ex	planation	:	
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С	Positio		
d	Addres	s:	e Telephone:
Ex	planation	:	

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110 1210 - 0089

2014

This Form is Open to Public Inspection

Part I Annual Report Id	lentification Information	<u>n</u>			
For calendar plan year 2014 or fis	cal plan year beginning (01/01/2014	and ending	12/31/2014	
A This return/report is for:	This return/report is for: a multiemployer plan; a multiple-employer plan (Filers checking this box must attach a list of				
B This return/report is:	the first return/report; an amended return/report;	the final return	the final return/report; a short plan year return/report (less than 12 months).		
C If the plan is a collectively-bargain Check box if filing under:	Form 5558; special extension (enter desc		ension;	the DFVC program;	
Part II Basic Plan Inforn	nation - enter all requested in	nformation			
1a Name of plan HATTIESBURG MEDICAL GROUP INSURANCE PLA	·	REST	1b 1c	Three-digit plan number (PN) ► 503 Effective date of plan 01/01/1994	
2a Plan sponsor's name and address; in	nclude room or suite number (emp	oloyer, if for a single-emplo	yer plan) 2b	Employer Identification Number (EIN) $64-0604714$	
				2c Plan Sponsor's telephone number (601)583-3232	
100 WEST PINE STREE	ST		2d	Business code (see instructions) 6 2 3 0 0 0	
HATTIESBURG 100 WEST PINE STREE					
HATTIESBURG	MS 39401				
Caution: A penalty for the late or inc		/report will be assesse	ed unless reasona	able cause is established.	
	forth in the instructions, I declare that I h	nave examined this return/report	t, including accompanyir	ng schedules, statements and attachments, as well	
SIGN HERE Signature of plan administra	ator Date	STEPH		REL ning as plan administrator	
SIGN / STATE & X MAKEL & STEPHEN A. WORREL				WORREL	
HERE Signature of employer/plan	sponsor Date	Enter nam	e of individual sign	ning as employer or plan sponsor	
SIGN HERE					
Signature of DFE	Date		e of individual sig		
Preparer's name (including firm nam	e, if applicable) and address (i	include room or suite nu	ımber) (optional)	Preparer's telephone number (optional)	
J FRANK BETTS, CPA			601-948-2924		
HADDOX REID EUBANI					
188 EAST CAPITOL STREET, STE 500 JACKSON MS 39201					
DACKBON	HU JJZUI				
For Paperwork Reduction Act Notice	ce and OMB Control Number	rs, see the instructions	for Form 5500.	Form 5500 (2014 v. 140124	

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