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

2015

This Form is Open to Public Inspection

Part I	Annual Report Ide	entification Information	1					
For cale	ndar plan year 2015 or fisca	l plan year beginning 01/01/2	2015		and ending 12/31/2	015		
A This	return/report is for:	a multiemployer plan;			loyer plan (Filers checking mployer information in acco			r
		X a single-employer plan;		a DFE (specify))			
B This	return/report is:	the first return/report;		the final return/	report;			
	o.u,opo	an amended return/report	t;	a short plan ye	ar return/report (less than 1	12 months).	
C If the	nlan is a collectively-hargai	ned plan, check here						
	_	_		_		_	_	
D Chec	k box if filing under:	Form 5558;		automatic exten	ision;	th	e DFVC program;	
,		special extension (enter de	scription)					
Part	II Basic Plan Infor	mation—enter all requester	d informatio	on				
	ne of plan SBURG MEDICAL PARK /	CONVA REST GROUP INSU	JRANCE PL	_AN			Three-digit plan number (PN) ▶ 503	3
1c Effective date of plan 01/01/1994								
Mail	ing address (include room, a	r, if for a single-employer plan) apt., suite no. and street, or P country, and ZIP or foreign po	.O. Box)	foreign and instru	uctional	2b	Employer Identification Number (EIN) 64-0604714	
-	BURG MEDICAL PARK MA		Stal Code (II	Toreign, see mstru	actions)	20	Plan Sponsor's telephone	_
						20	number 601-583-3232	Э
100 WEST PINE STREET HATTIESBURG, MS 39401 100 WEST PINE STREET HATTIESBURG, MS 39401				2d	Business code (see instructions) 623000			
							623000	
Caution	: A penalty for the late or i	incomplete filing of this retu	ırn/report v	vill be assessed u	unless reasonable cause	is establi	shed.	
Under pe	enalties of perjury and other	penalties set forth in the instr I as the electronic version of tl	uctions, I de	eclare that I have e	examined this return/report	, including	accompanying schedules,	
SIGN	Filed with authorized/valid	electronic signature.		10/10/2016	STEPHEN A. WORREL			
HERE	Signature of plan admini	<u> </u>	ı	Date	Enter name of individual:	nter name of individual signing as plan administrator		
	Orginatar o or prair aurimi	oti atoi		24.0	Emor name of marriadar	orgrinig ao	pian administrator	
SIGN								
HERE	Signature of employer/pl	lan snonsor		Date	Enter name of individual	sianina as	employer or plan sponsor	
	Orginatare or emproyer/pr	ан эропээг		Date	Enter name of marriadars	oigining ao	employer of plan oponoor	_
SIGN								
HERE	Signature of DFE			Date	Enter name of individual	cianina ac	DEE	
Preparei		ne, if applicable) and address					telephone number	
	3 (2 2 2 3	., .,,	(,		·	
					_			

Form 5500 (2015) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor					3b A	Administrator's EIN
							dministrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	/report filed fo	or this	plan, en	er the name	, 4b E	EIN
а	Sponsor's name					4c P	'n
5	Total number of participants at the beginning of the plan year					5	574
6	Number of participants as of the end of the plan year unless otherwise states 6a(2), 6b, 6c, and 6d).	d (welfare pla	ns com	plete or	lly lines 6a(1),	
a(1	Total number of active participants at the beginning of the plan year					6a(1) 574
a(2	2) Total number of active participants at the end of the plan year					6a(2	2) 665
b	Retired or separated participants receiving benefits					6b	
С	Other retired or separated participants entitled to future benefits					6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c.					6d	665
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 complete this item)				ans	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	multiemploye	r plans	comple	te this item) .	····· 7	
	If the plan provides pension benefits, enter the applicable pension feature could be pension fea	es from the L	ist of F	Plan Cha	racteristics C	Codes in the	instructions:
9a	Plan funding arrangement (check all that apply) (1) Insurance	9b Plan b	enefit a	arrangen Insura	nent (check a nce	all that apply	/)
	(2) Code section 412(e)(3) insurance contracts	(2)				e)(3) insurar	nce contracts
	(3) Trust	(3)	_	Trust			
10	(4) X General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4)	where		al assets of t		ached. (See instructions)
	Pension Schedules			edules	,		ionidai (God indiadaidhe)
u	(1) R (Retirement Plan Information)	(1)			(Financial I	nformation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	X	_6_ A	(Financial II (Insurance (Service Pr	Information	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)			(DFE/Partion (Financial)		n Information) Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)		
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)			
11b Is the plan	currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)		
enter the R	eceipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, eceipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure alid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)		

Form 5500 (2015)

Receipt Confirmation Code__

Page 3

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

2015

This Form is Open to Public

		pursuant to E	RISA section 103(a)(2)				Inspection
For calendar plan year 2015	or fiscal plan	year beginning 01/01/2015		and en	ding 12/3	1/2015	•
A Name of plan HATTIESBURG MEDICAL F	PARK / CON	VA REST GROUP INSURANCE	PLAN	B Three-digit plan number (PN) ▶		۷) 🕨	503
C Plan sponsor's name as s HATTIESBURG MEDICAL F					yer Identific 0604714	ation Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance carried SUN LIFE ASSURANCE COM		CANADA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
38-1082080	0802	227420	632		01/01/2015	5	12/31/2015
2 Insurance fee and commis descending order of the ar		tion. Enter the total fees and tota	ıl commissions paid. Li	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total am	ount of comn			(b) To	otal amount	of fees paid	
		21539					0
3 Persons receiving commis	ssions and fe	es. (Complete as many entries a	as needed to report all	persons).			
		nd address of the agent, broker, o		m commiss	ions or fees	were paid	
BANCORPSOUTH INSURAN	ICE SERVIC		X 1976 SBURG, MS 39403				
(b) Amount of sales and	base	Fees	s and other commission	ns paid			
commissions paid		(c) Amount	(d) Purpose				(e) Organization code
21539							3
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		y	·			·	
(b) Amount of sales and	base	Fees	s and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpose	е		(e) Organization code

Page 2 - 1	
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(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	-	·	
		Fees and other commissions paid	
(b) Amount of sales and base			(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) No	me and address of the agent broke	r or other person to whom commissions or fees were poid	
(a) Na	ine and address of the agent, broke	r, 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
•	•	, , ,	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	4.50
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
confinissions paid	(C) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)			
(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	r, 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
	(-)	727	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contra	cts with each carrie	er may be treated 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 en				
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	nu	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan.	check here	П	
7		racts With Unallocated Funds (Do not include portions of these contracts ma			Ш	
•	a			tion guarantee		
	а	(3) guaranteed investment (4) other		tion guarantee		
	b c	Balance at the end of the previous year			7b	
		(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
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	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	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	0

	Schedule A (Form 5500) 2015		Page	4	
rt I	II Welfare Benefit Contract Information If more than one contract covers the same group information may be combined for reporting purp the entire group of such individual contracts with	up of employees of the sar	e experience-i	rated as a unit. Where contrac	
Ber	nefit and contract type (check all applicable boxes)				
а	Health (other than dental or vision)	Dental	c V	/ision	d Life insurance
е	Temporary disability (accident and sickness) f	Long-term disability	g∏s	Supplemental unemployment	h Prescription drug
i	Stop loss (large deductible)	HMO contract	_ =	PPO contract	I Indemnity contract
m		Ш			L ,
•••					
Exp	erience-rated contracts:				
a [']	Premiums: (1) Amount received		9a(1)		
	(2) Increase (decrease) in amount due but unpaid		9a(2)		
	(3) Increase (decrease) in unearned premium reser	ve	9a(3)		
	(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))			· ·	
	(4) Claims charged			9b(4)	
С	Remainder of premium: (1) Retention charges (on	· · · · · · · · · · · · · · · · · · ·			<u> </u>
	(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	9	9c(1)(D)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

207805

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

10 Nonexperience-rated contracts:

Part III

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

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

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier

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

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

Part I	/ Provision of Information			
11 Di	I the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(E)

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

2015

		pursuant to EF	RISA section 103(a)(2)				Inspection
For calendar plan year 20	15 or fiscal plar	year beginning 01/01/2015		and en	ding 12/3	31/2015	
A Name of plan HATTIESBURG MEDICA	VA REST GROUP INSURANCE I	PLAN		e-digit number (Pl	N) •	503	
C Plan sponsor's name a HATTIESBURG MEDICA					oyer Identific 0604714	cation Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		CANADA					
/b) [IN]	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
38-1082080	80802	10829	315		01/01/201	5	12/31/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. Li	st in line 3	the agents,	brokers, and of	ther persons in
(a) Total a	amount of comr	·		(b) To	otal amount	of fees paid	
		4808					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	ıs needed to report all ı	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	
BANCORPSOUTH INS SE	RVICES INC	P.O. BO HATTIES	X 1976 SBURG, MS 39403				
(b) Amount of sales ar	nd hase	Fees	and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose				(e) Organization code
4808							3
	(a) Name a	nd address of the agent, broker, c	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	Fees	and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
For Donomicarly Dodicatio	n Act Notice o	nd OMD Central Numbers and	the instructions for E	orm EEOO			

Page 2 - 1	
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(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	-	·	
		Fees and other commissions paid	
(b) Amount of sales and base			(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) No	me and address of the agent broke	r or other person to whom commissions or fees were poid	
(a) Na	ine and address of the agent, broke	r, 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
•	•	, , ,	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	Fees and other commissions paid		4.50
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
confinissions paid	(C) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)			
(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	r, 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
	(-)	727	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contra	cts with each carrie	er may be treated 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 en				
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	nu	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan.	check here	П	
7		racts With Unallocated Funds (Do not include portions of these contracts ma			Ш	
•	a			tion guarantee		
	а	(3) guaranteed investment (4) other		tion guarantee		
	b c	Balance at the end of the previous year			7b	
		(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
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	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	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	0

Schedule A (Form 5500) 2015		Page 4		
I Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the same ourposes if such contracts are e	experience-rated	as a unit. Where contract	
efit and contract type (check all applicable boxes))			
Health (other than dental or vision)	b Dental	C Vision	I	d Life insurance
Temporary disability (accident and sickness)	f X Long-term disability	g Suppl	emental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k∏ PPO d	contract	I Indemnity contract
Other (specify)	,a saaa.		, o made	
_ Other (specify) •				
erience-rated contracts:				
Premiums: (1) Amount received	9	a(1)		
(2) Increase (decrease) in amount due but unpai	d9	a(2)		
(3) Increase (decrease) in unearned premium res	serve9	a(3)		
(4) Earned ((1) + (2) - (3))	<u></u>		9a(4)	
Benefit charges (1) Claims paid	9	b(1)		
(2) Increase (decrease) in claim reserves	9	b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c	(1)(A)		
(B) Administrative service or other fees	9c	(1)(B)		
(C) Other specific acquisition costs	9c	(1)(C)		
(D) Other expenses	9c	(1)(D)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

53476

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

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Experience-rated contracts:

Part III

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

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

(H) Total retention

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

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

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier

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

Part	V Provision of Information			
11 D	d the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(E)

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

2015

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	15 or fiscal pla	n year beginning 01/01/2015		and en	ding 12/3	31/2015	
A Name of plan HATTIESBURG MEDICAL PARK / CONVA REST GROUP INSURANCE PLAN			E PLAN		e-digit number (Pl	N) •	503
	C Plan sponsor's name as shown on line 2a of Form 5500 HATTIESBURG MEDICAL PARK MANAGEMENT CORP				yer Identific 0604714	cation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca SUN LIFE ASSURANCE C		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	315	i	01/01/201	5	12/31/2015
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
590 0							
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all	persons).			
		and address of the agent, broker		m commiss	ions or fees	were paid	
BANCORPSOUTH INS SE	RVICES INC	P.O. E HATTI	3OX 1976 IESBURG, MS 39403				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	Э		(e) Organization code
	590						3
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code

Page 2 - 1	
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Schedule A (Form 5500) 2015 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (b) Amount of sales and base (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 individual report.	idual contra	cts with each carrie	er may be treated 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 en				
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	nu	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan.	check here	П	
7		racts With Unallocated Funds (Do not include portions of these contracts ma			Ш	
•	a			tion guarantee		
	а	(3) guaranteed investment (4) other		tion guarantee		
	b c	Balance at the end of the previous year			7b	
		(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
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	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	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	0

Sc	hedule A (Form 5500) 2015		Pa	ge 4	
If ir	Velfare Benefit Contract Informat more than one contract covers the same graformation may be combined for reporting pune entire group of such individual contracts w	oup of employees of the surposes if such contracts a	are experienc	e-rated as a unit. Where contra	
Benefit an	nd contract type (check all applicable boxes)				
a Hea	alth (other than dental or vision)	b Dental	С	Vision	d X Life insurance
e Ter	mporary disability (accident and sickness)	f Long-term disabilit	у д [Supplemental unemployment	h Prescription drug
	p loss (large deductible)	j HMO contract		PPO contract	I Indemnity contract
=	ner (specify)	, 🗆 saas.		1	- 🗀asy ssas.
🗆 🔾 0	iei (specify)				
Experienc	e-rated contracts:				
•	ums: (1) Amount received		9a(1)		
(2) In	crease (decrease) in amount due but unpaid		9a(2)		
(3) In	crease (decrease) in unearned premium res	erve	9a(3)		
(4) Ea	arned ((1) + (2) - (3))			9a(4))
b Bene	efit charges (1) Claims paid		9b(1)		
(2) In	crease (decrease) in claim reserves		9b(2)		
` '	curred claims (add (1) and (2))			<u></u>)
(4) C	laims charged			9b(4))
C Rem	ainder of premium: (1) Retention charges (o	n an accrual basis)			
(/	A) Commissions		9c(1)(A)		
(1	B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs		9c(1)(C)		
(1	D) Other expenses		9c(1)(D)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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

10 Nonexperience-rated contracts:

Part III

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

(H) Total retention

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

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

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

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

9c(1)(E)

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

2015

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015 A Name of plan HATTIESBURG MEDICAL PARK / CONVA REST GROUP INSURANCE PLAN B Three-digit plan number (PN)	503				
HATTIECHIDO MEDICAL DADIZ / CONVA DECT CHOUD INCLIDANCE DI AN	503				
C Plan sponsor's name as shown on line 2a of Form 5500 HATTIESBURG MEDICAL PARK MANAGEMENT CORP D Employer Identification Number (EIN) 64-0604714					
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.	ion for each contract				
1 Coverage Information:					
(a) Name of insurance carrier SUN LIFE ASSURANCE COMPANY OF CANADA					
(b) EIN (c) NAIC (d) Contract or persons covered at end of	ract year				
(b) EIN (c) NAIC (d) Contract of persons covered at end of policy or contract year (f) From	(g) To				
38-1082080 80802 10829 315 01/01/2015 12	12/31/2015				
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other descending order of the amount paid.	er persons in				
(a) Total amount of commissions paid (b) Total amount of fees paid	(b) Total amount of fees paid				
99	0				
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
BANCORPSOUTH INS SERVICES INC P.O. BOX 1976 HATTIESBURG, MS 39403					
(b) Amount of sales and base Fees and other commissions paid					
	(e) Organization code				
99					
(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					
, ,	(e) Organization code				

Page 2 - 1	
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Schedule A (Form 5500) 2015 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contra	cts with each carrie	er may be treated 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 en				
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	nu	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan.	check here	П	
7		racts With Unallocated Funds (Do not include portions of these contracts ma			Ш	
•	a			tion guarantee		
	а	(3) guaranteed investment (4) other		tion guarantee		
	b c	Balance at the end of the previous year			7b	
		(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
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	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	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	0

Schedule A (Form 5500) 2015		Page 4		
If more than one contract covers the same goinformation may be combined for reporting the entire group of such individual contracts	roup of employees of the sa ourposes if such contracts ar	e experience-rated as	a unit. Where contrac	
Benefit and contract type (check all applicable boxes)			
a Health (other than dental or vision)	b Dental	C Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	g Suppleme	ntal unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k ☐ PPO cont		I Indemnity contract
m X Other (specify) ▶AD&D	<i>,</i> –	Ш		
The Grief (Speedily) The Ge				
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpa	id	9a(2)		
(3) Increase (decrease) in unearned premium re	serve	9a(3)		
(4) Earned ((1) + (2) - (3))	<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)	
c Remainder of premium: (1) Retention charges (·	.		
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs	hand the second	9c(1)(C)		
(D) Other expenses		9c(1)(D)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

1110

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

10 Nonexperience-rated contracts:

Part III

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

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

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier

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

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

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

9c(1)(E)

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

2015

			RISA section 103(a)(2).	Inis Fo	rm is Open to Public Inspection	
For calendar plan year 20	15 or fiscal plan	year beginning 01/01/2015	and en	nding 12/31/2015	•	
A Name of plan HATTIESBURG MEDICA	L PARK / CON	VA REST GROUP INSURANCE F	DL A NI	e-digit number (PN)	503	
C Plan sponsor's name as shown on line 2a of Form 5500 HATTIESBURG MEDICAL PARK MANAGEMENT CORP D Employer Identification Number (EIN) 64-0604714						
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca NATIONAL GUARDIAN LII						
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
39-0493780	66583	2HATM115	454	01/01/2015	12/31/2015	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
		7223			0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).			
		nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid		
BANCORPSOUTH INS SE	RVICES INC	P.O. BO. BATON	X 3809 ROUGE, LA 70821-3809			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	(e) Organization code		
	7223				3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	sions or fees were paid		
		V				
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code	
For Panerwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500			

Page 2 - 1	
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Schedule A (Form 5500) 2015 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contra	cts with each carrie	er may be treated 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 en				
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	nu	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan.	check here	П	
7		racts With Unallocated Funds (Do not include portions of these contracts ma			Ш	
•	a			tion guarantee		
	а	(3) guaranteed investment (4) other		tion guarantee		
	b c	Balance at the end of the previous year			7b	
		(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
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	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	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	0

Schedule A (Form 5500) 2015	Page 4	
	e same employer(s) or members of the same employee organizations(s), the same experience-rated as a unit. Where contracts cover individual employee treated as a unit for purposes of this report.	
efit and contract type (check all applicable boxes)		
Health (other than dental or vision) b Dental	c ✓ Vision d ☐ Life insurance	
Temporary disability (accident and sickness) f Long-term disal	oility $g \square$ Supplemental unemployment $h \square$ Prescription drug	
Stop loss (large deductible) j HMO contract	k PPO contract I I Indemnity contract	
Other (specify)		
erience-rated contracts:		
Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))		
Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))		
(4) Claims charged	9b(4)	
Remainder of premium: (1) Retention charges (on an accrual basis)		
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Experience-rated contracts:

Part III

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

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

(D) Other expenses.....

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

(H) Total retention

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

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier

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

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

9c(1)(C)

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

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

2015

nursuant to EDICA continu 400(a)(0)					m is Open to Public Inspection		
For calendar plan year 20	15 or fiscal pla	an year beginning 01/01/2015		and en	nding 12/3	1/2015	
A Name of plan HATTIESBURG MEDICAL PARK / CONVA REST GROUP INSURANCE OF THE PROPERTY OF THE P			E PLAN		e-digit number (PN	1)	503
C Plan sponsor's name as shown on line 2a of Form 5500 HATTIESBURG MEDICAL PARK MANAGEMENT CORP D Employer Identification Number (EIN) 64-0604714 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each						EIN)	
on a separat		ning Insurance Contract . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca IRONSHORE INDEMNITY							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a			Policy or co	ontract year I
(6) LIN	code	identification number	policy or contrac		(f)	From	(g) To
41-0121640	23647	ERR000000057-01	665	5	01/01/2015	5	12/31/2015
2 Insurance fee and composite descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
		nmissions paid		(b) To	otal amount	of fees paid	
		0					0
3 Persons receiving com		fees. (Complete as many entrie					
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code
	(a) Name	and address of the agent, broke	er or other person to who	m commiss	ions or fees	were paid	
	(a) wame	and dadiooc of the agont, broke	n, or ourse person to will		10010 01 1000	woro para	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

Page 2 - 1	
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Schedule A (Form 5500) 2015 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions 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 Fees and other commissions paid (b) Amount of sales and base (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 individual report.	idual contra	cts with each carrie	er may be treated as	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	4			
		ent value of plan's interest under this contract in separate accounts at year en				
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	nu	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan.	check here	П	
7		racts With Unallocated Funds (Do not include portions of these contracts ma			Ш	
•	a			tion guarantee		
	а	(3) guaranteed investment (4) other		tion guarantee		
	b c	Balance at the end of the previous year			7b	
		(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
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	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	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	0

Schedule A (Form 5500) 2015	Page	. 4	
information may be combined for reporting	nation e group of employees of the same employers g purposes if such contracts are experience- ts with each carrier may be treated as a unit	rated as a unit. Where contract	
Benefit and contract type (check all applicable box	es)		
a Health (other than dental or vision)	b Dental c V	√ision	d Life insurance
e Temporary disability (accident and sickness	s) f Long-term disability g	Supplemental unemployment	h Prescription drug
i Stop loss (large deductible)		PPO contract	I Indemnity contract
	,		
m ☐ Other (specify)			
Experience-rated contracts:			
a Premiums: (1) Amount received		486066	
(2) Increase (decrease) in amount due but un			
(3) Increase (decrease) in unearned premium			
(4) Earned ((1) + (2) - (3))		9a(4)	486066
b Benefit charges (1) Claims paid	9b(1)	324727	
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	324727
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charge	s (on an accrual basis)		_
(A) Commissions			_
(B) Administrative service or other fees			
(C) Other specific acquisition costs			
(D) Other expenses	9c(1)(D)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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

10 Nonexperience-rated contracts:

Part III

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

(H) Total retention

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

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

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

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

9c(1)(E)

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 **Service Provider Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2015

This Form is Open to Public Inspection.

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015	and ending 12/31/2015
A Name of plan HATTIESBURG MEDICAL PARK / CONVA REST GROUP INSURANCE PLAN	B Three-digit plan number (PN) 503
Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (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 or more in total compensation (i.e., money or anything else of monetary value) in connectiplan 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	on with services rendered to the plan or the person's position with the ch the plan received the required disclosures, you are required to
Information on Persons Receiving Only Eligible Indirect Compensa	ation
Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of	
indirect compensation for which the plan received the required disclosures (see instruction	s for definitions and conditions)
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 in	
(b) Enter name and EIN or address of person who provided you of	disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you	disclosure on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you of	disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you of	disclosures on eligible indirect compensation

Page 3 - 1	

(f). If none, enter -0-.

Yes No

Schedule C (Form 5500) 2015 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 HEALTHCARE SERVICES, INC. 9900 BREN ROAD MN008-T390 MINNETONKA, MN 55343 41-1289245 (b) (c) (d) (e) (f) (h) (g) Service Relationship to Enter direct Did service provider Did indirect compensation Enter total indirect Did the service include eligible indirect Code(s) employer, employee | compensation paid receive indirect compensation received by provider give you a organization, or by the plan. If none, compensation? (sources compensation, for which the service provider excluding formula instead of plan received the required person known to be enter -0-. other than plan or plan eligible indirect an amount or compensation for which you a party-in-interest sponsor) disclosures? estimated amount? answered "Yes" to element (f). If none, enter -0-. CLAIMS PROCESSOR 12 49 386076 Yes X No Yes No X Yes X No (a) Enter name and EIN or address (see instructions) BANCORPSOUTH INS SERVICES, INC. P.O. BOX 250 GULFPORT, MS 39502-0250 72-1381997 (b) (c) (d) (e) (f) (g) (h) Enter direct Did service provider Did indirect compensation Service Relationship to Enter total indirect Did the service Code(s) employer, employee compensation paid receive indirect include eligible indirect compensation received by provider give you a compensation, for which the organization, or by the plan. If none formula instead of compensation? (sources service provider excluding person known to be enter -0-. other than plan or plan plan received the required eligible indirect an amount or compensation for which you estimated amount? a party-in-interest sponsor) disclosures? answered "Yes" to element (f). If none, enter -0-. 55 **BROKER** 25274 Yes No X Yes X No Yes No X (a) Enter name and EIN or address (see instructions) (b) (d) (e) (f) (h) (c) (g) Service Relationship to Enter direct Did service provider Did indirect compensation Enter total indirect Did the service employer, employee compensation paid receive indirect include eligible indirect compensation received by provider give you a Code(s) organization, or by the plan. If none compensation? (sources compensation, for which the service provider excluding formula instead of person known to be enter -0-. other than plan or plan plan received the required eliaible indirect an amount or a party-in-interest sponsor) disclosures? compensation for which you estimated amount? answered "Yes" to element

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

Part I Service Provider Information (continued)

(d) Enter name and EIN (address) of source of indirect compensation

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 may questions 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 recordkeepir direct compensation and (b) each s	ng services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	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	(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 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

(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Page 5-

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

Page	6-
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D-	rt III	Tormination Information on Accountants and Enrelled Actuaries (see	instructions)		
ra	II C III	Termination Information on Accountants and Enrolled Actuaries (see (complete as many entries as needed)	msu ucuons)		
а	Name:		b EIN:		
С	Positio	n:			
d	Addres	s:	e Telephone:		
	.				
ΕX	olanatior				
а	Name:		b EIN:		
С	Positio	n:			
d	Addres		e Telephone:		
EX	olanatior	I.			
а	Name:		b EIN:		
C	Positio	n:	D LIN.		
d	Addres		e Telephone:		
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	N1		b EIN:		
<u>а</u> с	Name: Positio	0.	D EIN:		
d	Addres		e Telephone:		
u	Addice	5.	C receptione.		
Ex	olanatior	t.			
			T		
<u>a</u>	Name:		b EIN:		
C	Positio		O Talanhana		
d	Addres	S:	e Telephone:		
Ex	Explanation:				
,					

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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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

2015

This Form is Open to Public Inspection

Torsion Salest Country Corporation	_			Public In	spection		
Part I Annual Report Identification							
For calendar plan year 2015 or fiscal plan year b	peginning 01/01/	2015 and ending	12/31	/2015			
A This return/report is for: a multiemploy		multiple-employer plan (Filer	_				
		articipating employer informa	ation in accordan	ce with the fo	orms instr.); or		
a single-emplo	<i>*</i>	DFE (specify)					
B This return/report is: the first return	' ' 	e final retum/report;					
an amended	_	short plan year return/report	t (less than 12 mo	onths).			
C If the plan is a collectively-bargained plan, checl			1	▶∐			
D Check box if filing under: X Form 5558;		utomatic extension;	the DFVC prog	jram;			
	sion (enter description)						
Part II Basic Plan Information - ente	r all requested information	 1.	1b Three-digit				
1a Name of plan	CONTIN DECT		plan number	(PN)	503		
HATTIESBURG MEDICAL PARK /	COMAN VEDI	-		Effective date of plan			
GROUP INSURANCE PLAN				01/01/1994			
2a Plan sponsor's name (employer, if for a single-emplo	over plan)		2b Employer Ide		lumber (EIN)		
Mailing address (include room, apt., suite no. and str				64-0604714			
City or town, state or province, country, and ZIP or fo	oreign postal code (if foreign, s	ee instructions)		lan Sponsor's telephone number			
HATTIESBURG MEDICAL PARK M	IANAGEMENT COR	· -)583-3232			
		:	2d Business co 623000	de (see instr	uctions)		
100 WEST PINE STREET		-					
TOO MEST LINE SIKEET							
HATTIESBURG MS	39401	, i					
IMITIEDDONG	, 33 232	ļ					
Caution: A penalty for the late or incomplete filin	g of this return/report wil	I be assessed unless reas	onable cause is	established.			
Under penalties of perjury and other penalties set forth in the instruct as the electronic version of this return/report, and to the best of my k	ions, I declare that I have examined nowledge and belief, it is true, corre	this return/report, including accompa ct, and complete.	nying schedules, state	ments and attach	hments, as well		
SIGN MR/ The North In 10/16 STEPHEN A. WORREL			DRREL				
HERE Signature of plan administrator	Date	Enter name of individual signing as plan administrator					
14/1/201	11 10/10/11	STEPHEN A. W	ORREI.				
SIGN MR/JUM/S WINL	10/10/19	Enter name of individual	ver or plan sr	onsor			
Signature ot/employer/plan sponsor	Date* /	Enter name of individuals	signing as employ	yer or plain of	3011001		
SIGN							
HERE Signature of DFE	Date	Enter name of individual	signing as DFE				
Preparer's name (including firm name, if applicable			Preparer's	telephone ni	umber		
Preparer's name (including firm name, if applicable) and address (include roo	in or salte name of					
					FF00 (00)		
For Paperwork Reduction Act Notice and OMB (Control Numbers, see the	instructions for Form 550	D.		orm 5500 (201 150123		

518401 12-07-15

Form 5500 (2015) Page 2								
3a	Plan administrator's name and address 🗵 Same as Plan Sponsor			rator's	ator's EIN			
		3c Admir				strator's telephone number		
4	If the name and/or EIN of the plan sponsor has changed since the last	eturn/report filed for this p	lan, enter the nar	ne,	4b EIN			
	EIN and the plan number from the last return/report:							
а	Sponsor's name				4c PN			
5	Total number of participants at the beginning of the plan year			5	<u> </u>	574		
6	Number of participants at the beginning of the plan year unless otherwise	stated (welfare plans com	olete only lines		·			
٠	6a(1), 6a(2), 6b, 6c, and 6d).	otatoo (tronta o piano com	,					
а	(1) Total number of active participants at the beginning of the plan year			6a(1)		574		
	(2) Total number of active participants at the end of the plan year			6a(2)		665		
	Retired or separated participants receiving benefits			6b				
	Other retired or separated participants entitled to future benefits			6c				
	Subtotal. Add lines 6a(2), 6b, and 6c			6d	<u></u>	665		
е	Deceased participants whose beneficiaries are receiving or are entitled	to receive benefits		6e				
f	Total. Add lines 6d and 6e			6f				
g	 9 Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested 							
h								
•								
7								
	complete this item)			7				
8a	If the plan provides pension benefits, enter the applicable pension feat	ure codes from the List of	Plan Characterist	tics Co	des in the instr	uctions:		
b 4 <i>7</i>	If the plan provides welfare benefits, enter the applicable welfare features $4B\ 4D\ 4E\ 4H$	re codes from the List of P	lan Characteristic	cs Code	es in the instru	ctions:		
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrang	ement (check all t	that ap	ply)			
	(1) Insurance	(1) Insurance						
	(2) Code section 412(e)(3) insurance contracts	· · · · · · · · · · · · · · · · · · ·	tion 412(e)(3) ins	urance	contracts			
	(3) Trust	(3) Trust						
	(4) X General assets of the sponsor		ssets of the spor					
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)							
ē	Pension Schedules	b General Schedule						
	(1) R (Retirement Plan Information)	`" H	(Financial In		•			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Mone				on - Smail Plan	1)		
	Purchase Plan Actuarial Information) - signed by the plan	, , H ——	(Insurance I					
	actuary	`' H	(Service Pro		•	· m)		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	`"' H			Plan Informatio			
_	Information) - signed by the plan actuary	(6)	G (Financial Tr	ansact	ion Schedules			