MONROE COUNTY
HUMAN SERVICES ADVISORY BOARD
Application for Funding
Fiscal Year 2012
October 1, 2011 – September 30, 2012

Agency Name	HospiceCare of Southeast Florida, Inc.
Physical Address	Corporate Office: 309 SE 18 Street
Mailing Address	
City, State, Zip	Fort Lauderdale, FL 33316
Phone	(954)467-7423
Fax	(954)745-0723
Email	ebetz@hospicecareflorida.org
Who should we contact with questions about this application?	Emily Betz

Amount received for prior fiscal year ending 09/30/10	$0
Amount received for current fiscal year ending 09/30/11	$0
Amount requested for upcoming fiscal year ending 09/30/12	$5,000

CERTIFICATION

To the best of our knowledge and belief, the information contained in this application and attachments is true and correct. Monroe County is hereby authorized to verify all information contained herein, and we understand that any inaccuracies, omissions, or any other information found to be false may result in rejection of this application. This certifies that this request for funding is consistent with our organization's Articles of Incorporation and Bylaws and has been approved by a majority of the Board of Directors.

We affirm that the Agency will use Monroe County funds for the purposes as submitted in this Application for Funding. Any change will require written approval from the Monroe County Board of County Commissioners.

We understand that the agency must substantially meet the eligibility criteria to be considered for Monroe County funding and that any applicable attachments not included disqualify the agency's application.

We understand that all funding received through this opportunity must be spent for the benefit of Monroe County.

We further understand that meeting the Eligibility Criteria in no way ensures that the agency will be recommended for funding by the Human Services Advisory Board. These recommendations are determined by service needs of the community, availability of funds, etc. HSAB funding recommendations must be approved by the Monroe County Board of County Commissioners.

Typed Name of Executive Director: Susan G. Telli

Signature Susan G. Telli

Date: 4-19-2011

Typed Name of Board President/Chairman: Janet Davis

Signature Janet Davis

Date: 4-19-11

Detailed instructions for each question appear in the separate instruction document.

1. Insert your agency's board-approved mission statement below.

It is the mission of **HospiceCare of Southeast Florida, Inc.** (HCSEF) to provide quality hospice care, support, and education to patients facing end of life, their families, and the community, regardless of ability to pay.

2. List the services your agency provides.

Hospice care and support services in patient's residence

- Pain and symptom management of terminal illness
- 24 hour pharmacy
- Medical supplies and durable medical equipment
- Clinical care and support provided by interdisciplinary team including physicians, nursing staff (RN, LPN, CNA), social workers, chaplains, grief support counselors, child life specialists, and trained volunteers
- Emotional, spiritual, and psychosocial support to patient and patient's family/loved ones
- 24 hour nursing advice and home visits
- Anticipatory grief counseling for family and loved ones

Forget Me Not Center

- Bereavement counseling for HCSEF's patient families and loved ones as well as the community at large
- Various supportive therapies including art therapy, pet therapy, drama therapy, and music therapy
- Grief support groups for adults and children
- Grief services for children in the public and private school system following sudden and tragic death

Grief Support Camps

- Complimentary weekend camp for children, ages 6-17, who have suffered from the death of a loved one
- Lodging, meals, and supplies are included
- Traditional, high energy camp activities combined with grief support and memorial activities to help the child recognize their grief and cope with their loss
- Camp reunion 6 weeks after the camp weekend

3. What services will be funded by this request?

Funding in the amount of $5,000 will be used to support Camp Coral, our annual grief support camp on Pigeon Key. Camp Coral is a complimentary camp for children who have suffered the loss of a loved one.

4. Funding category: If you have been previously funded by HSAB, do you request to have the HSAB consider changing your funding category? Please circle yes or no: Yes No

   If yes, please circle the new category for which you would like to be considered:
   Medical Core Services Quality of Life

   If you have not been previously funded, please circle the funding category that you believe best matches your services: Medical Core Services Quality of Life

5. Will County HSAB funds be used as match for a grant?

No. HCSEF has been recommended for funding for Camp Coral through the Monroe County Sheriff's Shared Asset Forfeiture Fund in the amount of $2,363. Matching funds are encouraged; however, there is not a match requirement for this funding.

6. If you answered "yes" to number four, please specify the:

   a. grant award title, granting agency, and purpose:

   b. grant amount:

   c. match percentage requirement and amount:

7. If your organization was funded with HSAB funds last year, please briefly and specifically explain:

   a. how the funds were spent

   b. how they were used to leverage additional funding.

8. Do you plan to allocate any part of this HSAB grant, if awarded, as a sub-grant to another organization? *If yes, please list the recipient(s), the purpose(s), and amount(s). Please make sure these are included on Attachment D, under "Grants to Other Organizations."*

No.

9. Does your organization allocate sub-grants to other organizations using other sources (non County) of funding? *If yes, please list the recipient(s), the purpose(s), and amount(s). Please make sure these are included on Attachment E, under "Grants to Other Organizations."*

No.

10. Will you or have you applied for other sources of County funding? If yes, please list source(s) and amount(s). *Also be sure to reflect this information on Attachment F.*

Yes, HCSEF applied for funding from the Monroe County Sheriff's Shared Asset Forfeiture Fund in the amount of $3,500. We have been recommended for funding in the amount of $2,363.

11. What needs or problems in this community does your agency address?

HCSEF's Camp Coral addresses the lack of grief counseling and support groups that directly focus on the unique needs of children coping with the loss of a loved one. There is a need for programs, like grief support camps, that allow children to recognize their grief, find a healthy outlet for their emotions, and decrease their feelings of isolation.

12. What statistical data support the needs listed in number nine?
(If applying for $5,000 or less, a response to question #12 is not required.)

13. What are the causes (not the symptoms) of these problems?
(If applying for $5,000 or less, a response to question #13 is not required.)

~~14. What does your agency do to address these causes?~~

14. Describe your target population as specifically as possible.

Camp Coral is available to children both male and female, ages 6-17, who have suffered the loss of a loved one. HCSEF places no restrictions on the type of death, the time frame since death, or the relationship the child had to the deceased in order to receive our services. HCSEF recognizes that all people grieve differently, especially children. Camp Coral addresses this need by providing various different therapies and activities during the camp weekend, so that each camper may grieve on their own terms. Camp Coral takes place on Pigeon Key, so preference is given to Monroe County residents.

15. How are clients referred to your agency?

HCSEF works directly with the Monroe County school system in order to ensure that we are available to all children who are in need of grief support. Letters and follow up phone calls are made to the guidance counselors at each Monroe County school. Students are referred to the Forget Me Not Center for grief support counseling year round through the recommendation of the child's guidance counselor. Many of these children go on to attend camp. HCSEF also contacts mental health agencies, churches, and other community organizations in Monroe County for camp referrals. HCSEF does extensive outreach and marketing in the community, so that all children who could benefit from the camp experience are aware of our services and are given the opportunity to attend.

16. What steps are taken to be sure that prospective clients are eligible and that the neediest clients are given priority?

Once a child is referred to our Forget Me Not Center for Camp Coral, the child undergoes a formal screening process. This process is used as a tool to ensure that the child is appropriate for camp and to determine how to best meet the child's needs in the camp environment. If the child is deemed inappropriate for the upcoming camp, grief support counseling is immediately available to address the child's emotional needs. The child may then be referred to one of our later camps in Miami-Dade or Broward County. (The same is true for campers in Miami-Dade and Broward. If they are not appropriate for the upcoming camp in their county of residence, they may be referred to our Monroe County camp.)

17. Describe any networking arrangements that are in place with other agencies.

HCSEF receives referrals from a variety of physicians and healthcare organizations in the surrounding area including the Good Health Clinic, the Rural Health Network, the Lower Keys Medical Center, and Middle Keys Guidance. HCSEF also has contract services with a variety of different providers, including Fisherman's Hospital in Marathon, Mariners Hospital, Inc. in Tavernier, and Plantation Key Convalescent Center, Inc. in Tavernier. Additionally, HCSEF receives referrals from members of the community who are familiar with our services and support our organization.

HCSEF has memberships with the Ocean Reef Chamber of Commerce, the Key Largo Chamber of Commerce, the Islamorada Chamber of Commerce, the Marathon Chamber of Commerce, the Lower Keys Chamber of Commerce, the Lower Keys Interagency Council, and the Business of Professional Women. HCSEF's medical director is affiliated with a number of different agencies, including the AIDS Help Board, the Julius Adams Task Force, the American Cancer Society, the Credentialing Committee, and the Pharmacy and Therapeutics Committee. These memberships allow our organization to maintain a strong presence within the community and to develop a heightened understanding of the issues and needs concerning Monroe County residents.

18. List all sites and hours of operation.

Home based care – Staff members visit clients in the home setting 24 hours a day.
Miami-Dade Office – 8405 NW 53 Street, Suite A-200, Doral, FL 33166
Broward Office – 309 SE 18 Street, Fort Lauderdale, FL 33316

The offices are open during regular business hours: Monday – Friday 8:00 – 5:00.
An on call nurse is available 24 hours a day, 7 days a week including holidays, so our patients and our patient families can reach us at anytime.

19. What financial challenges do you expect in the next two years, and how do you plan to respond to them?
(If applying for $5,000 or less, a response to question #19 is not required.)

20. What organizational challenges do you expect in the next two years, and how do you plan to respond to them?
(If applying for $5,000 or less, a response to question #20 is not required.)

21. How are clients represented in the operation of your agency?

Each patient is involved in determining their own plan of care when receiving hospice services, so the care that each patient receives is very individual and reflects their wishes. A variety of factors are taken into account when the patient and the clinical staff decide on the plan of care, including the patient's diagnosis, physical assessment, culture, religion, traditions, and personal preference. HCSEF strives to allow each patient to face end of life in accordance with their own wishes.

Our clients are also represented in other facets of the organization from the Board of Directors to the volunteers. HCSEF offers not only clinical support to the patient, but also offers emotional and grief support to the family. Many of our staff members, volunteers, and board members are involved in our organization because they have had a personal hospice experience. This can be seen when a patient's family member serves as a volunteer, or when a former camper returns as a counselor. HCSEF encourages all members of the community, especially those who have been touched by our services, to become engaged and involved in our organization. The support that we receive from our past clients allows us to better serve our future clients.

22. Is your agency monitored by an outside entity? If so, by whom and how often?
(If applying for $5,000 or less, a response to question #22 is not required.)

23. 510.61 hours of program service were contributed by 30 volunteers in the last year.

24. Will any services funded by the County be performed under subcontract by another agency? If so, what services, and who will perform them?

No.

25. What measurable outcomes do you plan to accomplish in the next funding year?

HCSEF plans to provide each child who attends camp with the supportive services necessary to learn coping skills and to recognize his/her grief in a healthy manner. An age appropriate post-camp evaluation is conducted to evaluate each child's experience. A camp reunion and follow up

counseling sessions are scheduled so that each child realizes that the camp support system continues after the conclusion of the camp weekend.

26. How will you measure these outcomes?
(If applying for $5,000 or less, a response to question #26 is not required.)

26. Provide information about units of service below. *(If applying for $5,000 or less, a response to question #26 is not required.)*

Service	Unit (hour, session, day, etc.)	Cost per unit (current year)

27. In 300 words or less, address any topics not covered above (optional).

The U.S. Census estimates that 1 in 20 children will lose a parent before they graduate from high school. In the United States alone, there are currently 3.5 million children under the age of 18 who have lost an immediate family member. Research from the American Academy of Child and Adolescent Psychiatry indicates that these children often manifest their grief through extended periods of depression, inability to sleep, loss of appetite, withdrawal from friends, and poor performance in school. These children are also at a greater risk for depression, poverty, substance abuse, and suicide. Children often feel isolated in their grief, but they rarely obtain formalized counseling, get the support they need in order to cope with death, or find a healthy outlet for their grief. Camp Coral is that outlet. At Camp, special activities are planned so that the children will be able to recognize their grief and come to terms with their loss. These activities are intended to provide a safe place for children to grieve with others who have similar emotional needs and experiences; allow children to share their feelings; normalize the grieving process; decrease feelings of isolation and build community; provide a framework and opportunity for discussion; teach coping skills; and create positive memories.

Camp Coral is a community of compassion and healing, and it doesn't end at the conclusion of camp. Our campers return for the camp reunion and for additional grief support; they often return as counselors when they are older; and they maintain their camp friendships long after the camp weekend has ended. The requested funding from the HSAB will allow HCSEF to continue to provide this invaluable service to the children of Monroe County, so that no child has to grieve alone.

Required Attachments

Required attachments were distributed to you as a separate document. Be sure to include these with your application. Please note: the required attachments A through F are only available in Microsoft Excel format. We require that you use this format, since it will automatically expand rows, generate totals and percentages, and align figures for easier reading.

ATTACHMENT CHECKLIST

LABEL AND ATTACH THE FOLLOWING IN THE ORDER SHOWN, AFTER THIS PAGE	ATTACHED?		COMMENTS
IF NOT APPLICABLE, PLEASE SO INDICATE AND EXPLAIN	YES	NO	You must explain any "NO" answers
A. Board Information Form	X		
B. Agency Compensation Detail	X		
C. Profile of Clients and Services	X		
D – F. Financial Information	X		
G. Copy of Audited Financial Statement from most recent fiscal year if organization's expenses are $150,000 or greater.	X		
H. Copy of IRS Form 990 from most recent fiscal year	X		
I. Copy of current fee schedule	X		
J. Copy of IRS Letter of Determination indicating 501 C 3 status	X		
K. Copy of Current Monroe County and City Occupational Licenses		X	Services are provided in the patient's home. There is no office, so there is no need for an occupational license.
L. Copy of Florida Dept. of Children And Families License or Certification		X	HCSEF services are not governed by DCF license.
M. Copy of any other Federal or State Licenses	X		
N. Copy of Florida Dept. of Health Licenses/Permits	X		
O. Copy of front page of Agency's EEO Policy/Plan	X		
P. Copy of Summary Report of most current Evaluation/Monitoring *	X		
Q. Data showing need for your program (optional, see question 7)		X	Not required to answer Question #7
R. Other (specify) TWO PAGE LIMIT	X		2010 Camp Coral flyer

* must include summary of deficiencies and suggested corrective action; may include your responses and actions taken.

ATTACHMENT A 1 - BOARD INFORMATION

This attachment has changed; please note additional information request at bottom of page.

2011

You must have at least five directors.

HospiceCare of Southeast Florida, Inc.

(enter your agency name in D-3 above and it will automatically appear in subsequent sheets)

Name/Board Position	Affiliation/Title	City/State	Telephone No.	Years Served	Current Term Expiration Date
Janet Davis - President	Philanthropist/Volunteer	Duck Key/Fort Lauderdale, FL	954-648-8654	4	6/30/2011
David Ray - Vice President	Associate - Hough Robson, PL	Fort Lauderdale, FL	954-239-4760	2	6/30/2011
Michelle Dallas - Secretary	Dentist - Las Olas Dental Center	Fort Lauderdale, FL	954-525-5055	4	6/30/2011
Jose Pagan - Treasurer	Banker	Miami, FL	954-684-1668	15	6/30/2011
Ann Lee	Retired - Broward County School Board	Fort Lauderdale, FL	954-581-6185	7	6/30/2011
James Murphy	Partner - Green, Murphy & Murphy, P.A.	Fort Lauderdale, FL	954-524-5105	18	6/30/2011
Patrick Naughton	Father - St. Elizabeth Ann Seton	Fort Lauderdale, FL	954-753-3330	2	6/30/2011
Tom Plachter	National Liquidators	Fort Lauderdale, FL	954-205-9805	1	6/30/2011
Karin Rhodes	Philanthropist/Volunteer	Fort Lauderdale, FL	954-524-5075	14	6/30/2011
John Ruddy	Retired - Defense Contractor	Fort Lauderdale, FL	954-525-7737	10	6/30/2011
Edward Skiff	President - Skiff & Company, Inc.	Fort Lauderdale, FL	954-793-8754	24	6/30/2011

****ATTACHMENT A 2 - EVIDENCE OF ANNUAL ELECTION OF OFFICERS (Please attach a copy of the minutes of the meeting in which the most recent elections took place.)**

Attachment A-2

1.10

Minutes of the Special Meeting
Of the
Board of Directors
September 14, 2010

Members Present:	Janet Davis, President; David Ray, Jose Pagan, Dr. Michelle Dallas, Ann Lee, James Murphy, PJ Naughton, Tom Plachter, Karin Rhodes, and Ned Skiff
Members Excused:	John Ruddy,
Staff Present:	Susan G. Telli, CEO; Esther Monzon-Aguirre, COO; Kathleen M. Palmer, CFO; Dr. Sreenivas Nara, Senior Medical Director, Mindy Diaz, Director of PI and Education and Kacey Benson, Finance Manager.

Janet Davis, Vice-President called the meeting to order at 6:00 PM. There was a quorum present. A motion was made by Jim Murphy to accept the resignation of Michael Robinson, Esq. from the Board of Directors, and the office of President. Second: Ned Skiff. Susan Telli will prepare a letter on behalf of HospiceCare of Southeast Florida, Inc. thanking Mike for his years of service to the organization. The motion carried with a unanimous aye vote of the members present.

A motion was made by Ned Skiff to nominate Janet Davis for President of the Board of Directors. Second: Dr. Michelle Dallas. Karin Rhodes, as a past President, accepted the request of the Board to serve as advisor to the President. The motion carried with a unanimous aye vote of the members present.

A motion was made by Ned Skiff to nominate David Ray to serve as Vice-President of the Board of Directors. Second: Tom Plachter. The motion carried with a unanimous aye vote of the members present.

TREASURER'S REPORT: Jose Pagan, Treasurer

The consolidated Financial Statements for the fiscal year ending July 31, 2010 reflect an operating loss of ($44,475) and a net loss for this month of ($38,616). The labor costs are the primary cause for the continuing operating loss, particularly in the Broward division. We are not able to achieve the economies of scale in this division, and the overtime costs are increasing as scheduling issues continue. Other variable patient related direct costs remain constant, as well as administrative costs. The community support for July is high at $31,142 due to the fact that an adjustment was made for the golf fundraising income of $24,000 for the postponement of the event to the new fiscal year, in September, 2010.

☐ 309 S.E. 18th Street, Fort Lauderdale, Florida 33316
(954) 467-7423 • (800) 372-1757 • Fax: (954) 524-6067

☐ 8405 NW 53rd Street, Ste. A-200, Doral, Florida 33166
(305) 599-7755 • (800) 372-1757 • Fax: (305) 599-3588

☐ 91256 Overseas Highway, Tavernier, Florida 33070
(305) 852-3223 • (800) 372-1757 • Fax: (305) 852-8223

www.hospicecareflorida.org

Certified by Medicare & Medicaid

Actual Community Support for the month of July is $7,142, with development and fundraising expenses incurred of $42,066 for this same period. The average daily patient census for the month of July 2010 remained constant at 339, distributed as follows: Broward at 133, Miami-Dade at 173, Monroe at 20, the John Knox Hospice Unit is at 5 and the Bougainvilla is at 8 patients per day. The Miami-Dade census continues to build, while Broward remains static. The census on August 31, 2010 is 350.

The patient revenue for this fiscal year is $1,880,181. The operating expenses for this same period are $1,924,656. This results in a year to date loss from operations of ($44,475), distributed as follows: the Broward Division, a loss of ($103,844), Miami-Dade, a gain of $106,011, Monroe, a loss of ($25,082), and the Bougainvilla's deficit is ($21,561). Charity care provided for indigent patients increased to $75,455 for the month of July 2010.

The Balance Sheet reflects current assets and liabilities. The cash flow is acceptable, but to maintain vendor payments at 60 days, with continued operating and net losses in the next few months will be difficult. The audit field work was completed by MarcumRachlin from August 9th through August 18, 2010, and went very well. We expect the final Audited Financial Report to be issued in September. Jose asked if there were any issues during the July 2010 report period, and Kathy Palmer reported that the reporting period was consistent with the past few months. Jose Pagan also clarified that the Medicare Aggregate Cap issues were prior to the month of July, and the financial statements reflect what we were aware of at this time. Jose Pagan reviewed the Operating Analysis for the fiscal year ending June 30, 2010. Kathy Palmer reported that the impact on the past fiscal years ending June 30, 2009 and June 30, 2010 have been reviewed with the auditors and will be restated and adjusted to report and accrue the Medicare Aggregate Cap liability.

Jose Pagan also reiterated the cash flow issues will be impacted not only by the Medicare Aggregate Cap overpayment due of $901,393, but by the continuing operational losses each month unless we address these recurring operational issues. Janet Davis asked about our volume of charity care, and Jose Pagan indicated that we will review all operational aspects of the business.

A motion by Jim Murphy to accept the Treasurer's Report as presented. Second: Dr. Michelle Dallas. There was no further discussion. The motion carried by unanimous aye vote of the members present.

NEW BUSINESS:

Medicare Aggregate Cap Overpayment for 2009 – HospiceCare of Southeast Florida Inc. received a registered letter from Medicare stating that our 2009 report analysis, and aggregate cap calculation provided by Medicare indicated that we have exceeded the aggregate cap per Medicare patient election for the period ending October 31, 2009, and have an overpayment immediately due of $901,393 to Medicare. We did not exceed the twenty percent limitation on Medicare Inpatient days.

Susan Telli reported that we have come to a point where the mission of HospiceCare of Southeast Florida Inc. must now become the business of hospice – a time for critical changes in the way we have been operating HospiceCare of Southeast Florida, Inc. to remain viable.

On April 3, 2010 an agreement was presented to the Executive Committee to authorize Esther Monzon-Aguirre to change the HospiceCare of Southeast Florida corporate and Broward division to a hospice business model with the mission based more on principles of business, as she had already accomplished in the Miami-Dade division.

Since then, the Executive Management team has been totally focused on operational issues and changes; on accountability and productivity. The positive aspect in this has been the dramatic impact and change on our focus to the broad view that any change we make has an effect on all aspects of our services. Esther Monzon-Aguirre assumed the responsibility for all divisions, and reports to Susan Telli on a weekly and monthly basis.

Our direction now is to continue the integration between clinical, administrative, financial and corporate services to accomplish this business model. We currently have an overall plan, which includes staffing models and census mix, as well as the development of hospice key indicators that Executive Management will prepare and focus on monthly. We have a sense of urgency as time is critical with the many changes coming from Health Care Reform.

Susan Telli requested that Mindy Diaz give the Board of Directors a brief overview of the regulations as they relate to the Medicare Aggregate Cap. Mindy Diaz provided an explanation to the Board, and a detailed memo of this explanation was provided to the Board. The prevailing issue we have is the long length of stays our patients have, combined with transfers from other hospices where we receive only a fraction, or partial credit for, the annual benefit amount determined by Medicare.

Kathy Palmer reported that we implemented the corrective action plan from the last time this overpayment happened in 2004. We established a Utilization Review Committee to review the long length of stay patients, and included a calculation as a regular part of our annual independent audit. We previously received legal advice from Denise Bonn, Esq. at NAHC that this overpayment amount is due to the Medicare program, and there is no appeal available to us. The primary reason that this happened again is that we had reported only 17 fractional Medicare beneficiaries, (patients who were admitted with previous hospice care provided by another hospice), during the 2009 cap period. On the Fractional Beneficiaries Summary provided by Medicare, there were a reported 91 patients, a significant difference from our 17, and equal to 43.8 patients. The system to determine a more accurate number of fractional beneficiaries will be implemented to provide a reliable report for this year's audit requirement, and to anticipate the 2010 effect. We knew that we were experiencing a significant increase of transfers from other hospices, but did not know that their remaining benefit was so limited.

Ned Skiff asked how it is that we were not aware of this discrepancy. Esther Monzon-Aguirre responded that there were a couple of reasons, we know that the calculation is verified as part of our audit, and in 2008 we changed to MISYS/Allscripts clinical management system, and 2009 was the first complete year we prepared the Medicare cap report using data from this system. New admissions were not coded with previous hospice data unless the admission was a direct transfer from another hospice. Medicare also enhanced their reporting of fractional beneficiaries, which increased significantly, and we have not had full integration between the administration, clinical and finance side of the house to keep us on track with the effect that the long length of stay patients we have, and the admissions required to cover these stays.

Esther Monzon-Aguirre stated that as of today have created a mechanism to accomplish this. Jose Pagan wanted to know why the auditors did not test to assure that this did not happen. Esther Monzon-Aguirre explained that if the data was incorrect, our internal calculation, and the auditor's verification, would be dependent on this data. We also immediately reported this issue to the auditors, and met with them to review the corrected data and recalculate the 2010 liability so that we will not be in this situation again. Kacey Benson reported that we are pulling all admissions, approximately 700 to date, to verify prior hospice stays and verify that the data is correct in the MISYS/Allscripts system, and that we account for all fractional beneficiaries, for the 2010 calculation. Janet Davis asked if we felt we are up to speed on this, and when this review is completed, we will be. Esther Monzon-Aguirre reiterated that we have to have this full integration of departments to manage the business.

The impact on our cash flow is the amount of $901,393 which will be immediately deducted from our Medicare payments. In addition, the 2010 liability will be due in 2011, and our current operating losses will add to this cash shortfall unless immediate steps are taken. We will now be required to use the reserved bequest funds to cover payroll. We had been doing well until this happened. Esther explained that we will be refining our use of the Utilization Review Committee. The Clinical Managers will review all 150 patients with long lengths of stay, to maintain a balance for a sound business practice and census mix. Esther Monzon-Aguirre explained that we have been primarily focused on increasing census.

Medicare Aggregate Cap Overpayment for 2010 – We have reviewed the Medicare Aggregate Cap calculation for HospiceCare of Southeast Florida Inc. for the October 31, 2010 report period which was provided to the auditors, the current length of stay for all active patients, and the actual and anticipated admissions through the Medicare Cap Report cutoff date of September 27, 2010. With no change in planned admissions, or discharge of patients with a long length of stay, the estimated overpayment due to the Medicare program is $675,000. Any additional admissions may reduce this amount; the number of admissions required by this date to offset the total amount is 59 patients.

Monroe Division Changes – Susan Telli reported that we will not be renewing the lease for the office in Tavernier. A new team will be created with oversight for patient care from SW 152nd Avenue, Miami to Key West to reduce costs in the Monroe Division.

Janet Davis and Jose Pagan observed that if we are moving forward, and as a result of this discussion, the Board of Directors will require a Business Plan, a reserve of 7 ½% to cover the estimated 2010 cap liability, budgeted and achieved operating profitability of a minimum of 5%, and every dollar of community support must go toward building a reserve fund.

The Board of Directors went into Executive Session. Following this session, Janet Davis reported that the following has been requested by the Board of Directors:

1. A Business Plan, including 12% profitability, to be prepared by September 21, 2010
2. A Cash Flow projection be prepared for the next six months
3. Improved Medicare screening on admission to determine fractional beneficiary status
4. A top to bottom cost analysis on every line item expense to determine savings
5. Report of profitability/loss on every cost center, including Broward, Miami-Dade, Monroe, Bougainvilla, John Knox Hospice Unit, the Forget Me Not Center, and the TiLLi Kids programs.
6. A monthly report on the liability for the Medicare Aggregate Cap, with weekly review by Executive Management.
7. Charity Care review and a limitation imposed, with the admission declined if we are unable to afford to provide the care.

OLD BUSINESS:

There was no new business presented.

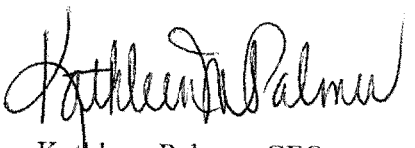
ADJOURNMENT:

There was no further business. The next meeting will be announced. The meeting adjourned at 7:45 PM.

Approved by:

Janet Davis
President

Respectfully submitted:



Kathleen Palmer, CFO as recorder
for Dr. Michelle Dallas, Secretary

ATTACHMENT B - AGENCY COMPENSATION DETAIL

2011

Include each position in the entire agency.
Put an "X" next to each position directly related to program for which funding is requested.
Please round all dollar amounts to the nearest dollar; do not round FTE'S.
A 40-hour/week employee would be 1.00 FTE; a 20-hour/week employee would be .5 FTE, etc.

HospiceCare of Southeast Florida, Inc.

		Proposed - Upcoming Year Ending:		Projected - Current Year Ending:	
		6/30/2012		6/30/2011	
Position Title	"X"	# FTE'S	Total Compensation Package	# FTE'S	Total Compensation Package
Administrator RN		1.00		1.00	
RN Case Manager		5.00	394,655	5.00	383,160
Licensed Practical Nurse		1.00	52,623	1.00	51,090
Certified Nursing Assistant		3.00	82,915	3.00	80,500
Social Worker		1.25	73,954	1.25	71,800
Chaplain		1.00	54,693	1.00	53,100
Volunteer Coordinator		0.50	23,999	0.50	23,300
Community Outreach		0.50	36,874	0.50	35,800
Team Associate/Clerical		0.50	22,763	0.50	22,100
Totals	**0**	**13.75**	**742,476**	**13.75**	**720,850**

ATTACHMENT C - PROFILE OF CLIENTS AND SERVICES (Performance Report)

2011

This attachment has changed; please note asterisked information at the bottom of page.
Delete or type over sample information shown.

HospiceCare of Southeast Florida, Inc.

List Services Here	Target Population	# of Persons in Target Population	Area	Days/Hours	Total Number of Clients Served during most recent completed fiscal year	Current # of Clients ("snapshot") as of 4/18/2010
Adult & Pediatric Hospice Services	Patients of any age diagnosed with a terminal illness and a life expectancy of six months or less	542	Monroe County	7 days/24 hours	98	17
Forget Me Not Center Grief Counseling	Any member of the community who has suffered from the death of a loved one	624	Monroe County	Weekdays 8:30 - 5:00	178	15
Camp Coral Grief Support Camp	Children, ages 6-17, who have suffered from the death of a loved one	98	Monroe County	1 weekend per year	24	10 at most recent camp in November
Unduplicated Clients for Entire Agency					200	75
(see instructions - this is not a total of the numbers above)						

Please indicate the number of clients served who are Monroe County residents:

Please list or describe achieved outcomes for your target populations: The goal of our hospice services is for the patient to experience a reduction in pain, an increase in comfortability, and improved quality of life. The Forget-Me-Not Center seeks to enable all members of the community dealing with a death to recognize their grief and find a healthy outlet to cope with loss. Camp Coral aims to allow children to share their feelings, normalize the grieving process, decrease feelings of isolation and build community, provide a framework and opportunity for discussion, teach coping skills, and create postive memories.

ATTACHMENT D - COUNTY FUNDING BUDGET

2011

Show the proposed budget detail for the County funds requested. **HospiceCare of Southeast Florida, Inc.**
The total must match with the total funding requested.

	Proposed Expense Budget for Upcoming Year Ending:	
	6/30/2011	
Expenditures	**Total**	**%**
Salaries	Volunteer	0.0%
Payroll Taxes	Volunteer	0.0%
Employee Benefits	Volunteer	0.0%
Subtotal Personnel	0	0
Postage	100	2.0%
Office Supplies		0
Telephone		0
Professional Fees		0
Rent		0
Utilities		0
Repair and Maint.		0
Travel		0
Miscellaneous		0
Grants to Other Organizations		0
List others below		0
Camp Fees	1,500	30.0%
Art Therapy	350	7.0%
Music Therapy	350	7.0%
Camper Meals	1,050	21.0%
Recreational Activities	600	12.0%
Camp Materials	1,050	21.0%
		0
		0
		0
		0
		0
		0
		0
		0
		0
		0
Total Expenses	**5,000**	**100.0%**

ATTACHMENT E - AGENCY EXPENSES

2011

Complete this worksheet for the entire agency.
Please round all amounts to the nearest dollar.

HospiceCare of Southeast Florida, Inc.

	Proposed Expense Budget for Upcoming Year Ending:		Projected Expenses for Current Year Ending:	
	6/30/2012		6/30/2011	
Expenditures	**Total**	**%**	**Total**	**%**
Salaries	11,440,232	46%	11,215,914	46%
Payroll Taxes	1,267,854	5%	1,242,994	5%
Employee Benefits	1,431,413	6%	1,403,346	6%
Subtotal Personnel	14,139,499	56%	13,862,254	56%
Postage	24,460	0%	23,980	0%
Office Supplies	126,613	1%	124,130	1%
Telephone	209,641	1%	205,530	1%
Professional Fees	174,920	1%	171,490	1%
Rent	178,908	1%	175,400	1%
Utilities	63,046	0%	61,810	0%
Repair and Maint.	115,229	0%	112,970	0%
Travel	536,336	2%	525,820	2%
Miscellaneous	2,603,954	10%	2,552,896	10%
Grants to Other Organizations				
List others below				
Prescription Drugs	1,019,194	4%	999,210	4%
Medical Equipment	1,487,293	6%	1,458,130	6%
Medical Supplies	726,587	3%	712,340	3%
Physician Services	638,826	3%	626,300	3%
Nutritional Supplements	268,280	1%	263,020	1%
Hospital Care	614,397	2%	602,350	2%
Nursing Home Services	1,861,612	7%	1,825,110	7%
Indigent Patient Care	305,980	1%	299,980	1%
Total Expenses	**25,094,774**	**100%**	**24,602,720**	**100%**
Revenue Over/(Under) Expenses	**0**		**0**	

ATTACHMENT F - AGENCY REVENUE

2011

Complete this worksheet for the entire agency.
Please round all amounts to the nearest dollar.
In-Kind will not be included in percentages or total.

HospiceCare of Southeast Florida, Inc.

	Proposed Revenue Budget for Upcoming Year Ending:			Projected Revenue for Current Year Ending:		
	6/30/2012			6/30/2011		
Revenue Sources	Cash	In-Kind	%-age of Total	Cash	In-Kind	%-age of Total
Monroe County	5,100		0%	5,000		0%
Children and Fam			0%			0%
M.C. Sheriff's Dept.			0%			0%
Key West			0%			0%
Marathon			0%			0%
Islamorada			0%			0%
Layton			0%			0%
Key Colony Beach			0%			0%
Client fees			0%			0%
Donations	1,178,383		5%	1,155,277		5%
Sheriff Shared Asset	2,410		0%	2,363		0%
United Way	102,000		0%	100,000		0%
List all others below			0%			0%
Medicare	20,260,658		81%	19,863,390		81%
Medicaid	3,200,362		13%	3,137,610		13%
Private Insurance	236,813		1%	232,170		1%
Private Pay	109,048		0%	106,910		0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			100%			**100%**
Total Revenue	**25,094,774**	0		**24,602,720**	0	

Attachment G

HOSPICECARE OF SOUTHEAST FLORIDA, INC.

FINANCIAL STATEMENTS

FOR THE YEAR ENDED JUNE 30, 2010

HOSPICECARE OF SOUTHEAST FLORIDA, INC.

CONTENTS

Independent Auditors' Report 1

Financial Statements

Statement of Financial Position 2

Statement of Activities 3

Statement of Functional Expenses 4

Statement of Cash Flows 5

Notes to Financial Statements 6-17

MARCUM
RACHLIN
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITOR'S REPORT

Board of Directors
HospiceCare of Southeast Florida, Inc.
Fort Lauderdale, Florida

We have audited the accompanying statement of financial position of HospiceCare of Southeast Florida, Inc. (a not-for-profit organization) as of June 30, 2010, and the related statements of activities, functional expenses and cash flows for the year then ended. These financial statements are the responsibility of the Organization's management. Our responsibility is to express an opinion on these financial statements based on our audit. The prior year summarized comparative information has been derived from the Organization's June 30, 2009 financial statements and, in our report dated September 2, 2009, we expressed an unqualified opinion on those financial statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HospiceCare of Southeast Florida, Inc. as of June 30, 2010, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 12 to the financial statements, the Organization corrected certain overstatements of previously reported revenues for the fiscal year ended June 30, 2009. Accordingly, the 2009 financial statements have been restated to correct the error.

MarcumRachlin

a division of Marcum LLP
Fort Lauderdale, Florida
September 17, 2010

MARCUMGROUP
MEMBER

MarcumRachlin a division of Marcum LLP ▫ **marcumrachlin.com**
450 East Las Olas Boulevard ▫ Ninth Floor ▫ Fort Lauderdale, Florida 33301 ▫ **Phone** 954.525.1040 ▫ **Fax** 954.525.2004
FLORIDA ▫ NEW YORK ▫ NEW JERSEY ▫ CONNECTICUT ▫ GRAND CAYMAN

HOSPICECARE OF SOUTHEAST FLORIDA, INC.

STATEMENT OF FINANCIAL POSITION

JUNE 30, 2010
(WITH COMPARATIVE TOTALS AS OF JUNE 30, 2009)

	2010			Restated 2009
	Unrestricted	Temporarily Restricted	Total	Total
Assets				
Cash and cash equivalents	$ 1,691,633	$ 5,992	$ 1,697,625	$ 792,093
Investments	960,838	--	960,838	619,915
Accounts receivable, net	2,216,894	--	2,216,894	3,048,826
Unconditional promises to give	--	52,359	52,359	52,181
Prepaid expenses	30,386	--	30,386	36,008
Inventories	34,573	--	34,573	40,082
Total Current Assets	4,934,324	58,351	4,992,675	4,589,105
Property and equipment, net	1,748,560	--	1,748,560	1,881,693
Interfund receivable (payable)	(23,086)	23,086	--	--
Other assets	25,647	--	25,647	25,647
Total Assets	$ 6,685,445	$ 81,437	$ 6,766,882	$ 6,496,445
Liabilities and Net Assets				
Current Liabilities				
Line of credit	$ 938,994	$ --	$ 938,994	$ 938,994
Accounts payable	983,160	--	983,160	1,362,138
Accrued expenses	2,339,316	--	2,339,316	1,631,739
Deferred revenue	25,000	--	25,000	--
Due to charitable gift annuitants	--	29,078	29,078	30,350
Current portion of capital lease obligation	--	--	--	64,652
Total Current Liabilities	4,286,470	29,078	4,315,548	4,027,873
Net Assets				
Unrestricted	2,398,975	--	2,398,975	2,416,391
Temporarily restricted	--	52,359	52,359	52,181
Total Net Assets	2,398,975	52,359	2,451,334	2,468,572
Total Liabilities and Net Assets	$ 6,685,445	$ 81,437	$ 6,766,882	$ 6,496,445

The accompanying notes are an integral part of these financial statements.

HOSPICECARE OF SOUTHEAST FLORIDA, INC.

STATEMENT OF ACTIVITIES

FOR THE YEAR ENDED JUNE 30, 2010
(WITH COMPARATIVE TOTALS FOR THE YEAR ENDED JUNE 30, 2009)

	2010			Restated 2009
	Unrestricted	Temporarily Restricted	Total	Total
Operating Revenues				
Medicare	$ 15,772,910	$ --	$ 15,772,910	$ 15,560,679
Medicaid	2,397,937	--	2,397,937	2,408,589
Insurance	87,571	--	87,571	312,515
Private pay	388,917	--	388,917	169,575
Grants from governmental agencies	--	--	--	23,026
Villa room and board	38,656	--	38,656	67,368
Registry services	11,620	--	11,620	4,254
Bereavement services	1,910	--	1,910	2,889
Total Operating Revenues	18,699,521	--	18,699,521	18,548,895
Operating Expenses				
Program services	16,723,656	--	16,723,656	16,997,724
Supporting services:				
Management and general	3,421,357	--	3,421,357	3,057,757
Development and fundraising	494,060	--	494,060	638,449
Total Operating Expenses	20,639,073	--	20,639,073	20,693,930
Change in Net Assets from Operations	(1,939,552)	--	(1,939,552)	(2,145,035)
Other Changes				
Public support:				
Contributions	1,470,670	--	1,470,670	795,222
Special events	209,574	--	209,574	420,019
United Way allocation	24,332	48,006	72,338	78,514
Donated facilities	65,000	--	65,000	65,000
Investment income (loss)	111,679	1	111,680	(39,475)
Other income	925	--	925	--
Change in value of split-interest agreements	--	(7,873)	(7,873)	(7,273)
Net assets released from restrictions	39,956	(39,956)	--	--
Total Other Changes	1,922,136	178	1,922,314	1,312,007
Increase (Decrease) in Net Assets	(17,416)	178	(17,238)	(833,028)
Net Assets - Beginning	2,416,391	52,181	2,468,572	3,301,600
Net Assets - Ending	$ 2,398,975	$ 52,359	$ 2,451,334	$ 2,468,572

The accompanying notes are an integral part of these financial statements.

HOSPICECARE OF SOUTHEAST FLORIDA, INC.

STATEMENT OF FUNCTIONAL EXPENSES

FOR THE YEAR ENDED JUNE 30, 2010
(WITH COMPARATIVE TOTALS FOR THE YEAR ENDED JUNE 30, 2009)

	2010					Restated 2009
	Program Services	Supporting Services				
	Public Health	Management and General	Fundraising	Total Supporting Services	Total	Total
Personnel Costs						
Salaries	$ 7,907,477	$ 1,635,674	$ 294,678	$ 1,930,352	$ 9,837,829	$ 9,626,809
Employee benefits	883,418	104,289	53,647	157,936	1,041,354	1,054,737
Payroll taxes	774,590	155,093	21,392	176,485	951,075	952,728
Total Personnel Costs	9,565,485	1,895,056	369,717	2,264,773	11,830,258	11,634,274
Other Expenses						
Patient care fees:						
Continuous care	298,067	--	--	--	298,067	852,441
Hospital inpatient	705,695	--	--	--	705,695	600,855
Physician services	618,208	--	--	--	618,208	413,715
Nursing home	1,532,444	--	--	--	1,532,444	1,626,268
Durable equipment	1,215,299	--	--	--	1,215,299	1,144,365
Prescriptions	733,481	--	--	--	733,481	850,219
Medical supplies	893,193	--	--	--	893,193	717,619
Other patient care fees	124,431	--	--	--	124,431	137,662
Bereavement Center	5,987	6,296	--	6,296	12,283	105,378
Travel	389,840	49,696	4,433	54,129	443,969	507,778
Advertising	36,738	31,418	22,119	53,537	90,275	166,435
Professional fees	68,197	154,266	--	154,266	222,463	207,348
Conferences, conventions and meetings	7,769	1,763	616	2,379	10,148	7,630
Occupancy	155,535	414,650	--	414,650	570,185	526,634
Office supplies	224,499	152,909	4,312	157,221	381,720	349,628
Charity care	--	416,978	--	416,978	416,978	173,493
Special events	--	--	91,753	91,753	91,753	172,363
Insurance	--	171,742	--	171,742	171,742	160,834
Interest expense	--	23,060	--	23,060	23,060	37,790
Other	18,366	74,373	1,110	75,483	93,849	132,446
Total Before Provision for Depreciation	16,593,234	3,392,207	494,060	3,886,267	20,479,501	20,525,175
Provision for Depreciation	130,422	29,150	--	29,150	159,572	168,755
Total Expenses	$ 16,723,656	$ 3,421,357	$ 494,060	$ 3,915,417	$ 20,639,073	$ 20,693,930

The accompanying notes are an integral part of these financial statements.

HOSPICECARE OF SOUTHEAST FLORIDA, INC.

STATEMENT OF CASH FLOWS

YEAR ENDED JUNE 30, 2010
(WITH COMPARATIVE TOTALS FOR THE YEAR ENDED JUNE 30, 2009)

	2010	Restated 2009
Cash Flows From Operating Activities		
Change in net assets	$ (17,238)	$ (833,028)
Adjustments to reconcile change in net assets to net cash and cash equivalents provided by (used in) operating activities:		
Provision for bad debts (charity care)	416,978	173,493
Depreciation	159,572	168,755
Unrealized (gains) losses on investments	(21,567)	47,760
Adjustment to split-interest agreements	7,873	7,273
Changes in assets and liabilities:		
(Increase) decrease in:		
Accounts receivable	414,954	(990,461)
Unconditional promises to give	(178)	30,000
Prepaid expenses	5,622	(6,879)
Inventories	5,509	(4,559)
Other assets	--	(3,161)
Increase (decrease) in:		
Accounts payable	(378,978)	146,562
Accrued expenses	707,577	417,585
Deferred revenue	25,000	--
Net Cash and Cash Equivalents Provided by (Used in) Operating Activities	1,325,124	(846,660)
Cash Flows from Investing Activities		
Acquisition of property and equipment	(26,439)	(84,040)
Purchases of investments	(545,222)	(624,360)
Proceeds from sales of investments	225,866	1,236,129
Net Cash and Cash Equivalents Provided by (Used in) Investing Activities	(345,795)	527,729
Cash Flows from Financing Activities		
Principal payments on capital lease	(64,652)	(104,198)
Principal repayments on line of credit agreement	--	(10,000)
Payments to annuitants	(9,145)	(9,145)
Net Cash and Cash Equivalents Used in Financing Activities	(73,797)	(123,343)
Net Increase (Decrease) in Cash and Cash Equivalents	905,532	(442,274)
Cash and Cash Equivalents - Beginning	792,093	1,234,367
Cash and Cash Equivalents - Ending	$ 1,697,625	$ 792,093
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid for interest	$ 23,060	$ 37,790
Cash received during the year for interest earned on investment activities	$ 33,646	$ 46,417

The accompanying notes are an integral part of these financial statements.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

NATURE OF ACTIVITIES

HospiceCare of Southeast Florida, Inc. (the Organization) is a not-for-profit corporation established to provide medically directed care to individuals who are suffering from life-limiting illnesses, and support services to their families and significant others. Care is provided regardless of the ability to pay. Funding sources include Medicare, Medicaid, insurance, private and public donations, grants, and memorial gifts. The Organization serves the community from a number of locations in Broward County, Miami-Dade County, and Monroe County, Florida.

BASIS OF ACCOUNTING AND PRESENTATION

The financial statements of the Organization have been prepared on the accrual basis of accounting. Financial statement presentation follows the recommendations of the accounting standards for financial statements of not-for-profit organizations. The Organization is required to report information regarding its financial position and activities according to three classes of net assets: permanently restricted net assets, temporarily restricted net assets, and unrestricted net assets. The Organization had no permanently restricted net assets as of June 30, 2010.

RESTRICTED AND UNRESTRICTED REVENUE AND SUPPORT

Contributions received are recorded as unrestricted or temporarily restricted, depending on the existence and/or nature of any donor restrictions.

Support that is restricted by the donor is reported as an increase in unrestricted net assets if the restriction expires in the reporting period in which the support is recognized. All other donor-restricted support is reported as an increase in temporarily restricted net assets, depending on the nature of the restriction. When a restriction expires (that is, when a stipulated time restriction ends or purpose restriction is accomplished), temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

REVENUE RECOGNITION AND CONCENTRATIONS

Contract revenue and third party payor revenue is recognized when earned. Grant revenue is recognized when allocated to the Organization. The Organization earns the majority of its revenue from the following two sources:

Medicare	84%
Medicaid	12%

Revenue from these sources is dependent on patient referrals and related census levels. Due to increased competition with other organizations receiving Medicare and Medicaid referrals, the Organization's revenues from these sources are subject to fluctuations each year.

PROMISES TO GIVE

Conditional promises to give are recognized as contribution revenue and receivables when the conditions are substantially met. Unconditional promises to give are recognized as contribution revenues and receivables in the period in which the promise is received. Depending on the existence and nature of donor-imposed restrictions, unconditional promises to give are reported either as unrestricted support that increases unrestricted net assets, or as restricted support that increases temporarily restricted net assets. The promises to give as of June 30, 2010 are unconditional and due within the current accounting period. Doubtful accounts on unconditional promises to give have been insignificant based on historical experience and management has deemed no allowance to be considered necessary.

CASH AND CASH EQUIVALENTS

The Organization considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents.

INVESTMENTS

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the statement of financial position. Investment income or loss (including realized and unrealized gains and losses on investments, interests and dividends) is included in the statement of activities as an increase or decrease in unrestricted net assets unless income or loss is restricted by donor or law. Restricted gains and investment income, where the restrictions are met in the same reporting period as the income is earned, are recorded as unrestricted support. The investments held by the Organization are pledged as collateral on the line of credit.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

INVENTORIES

Inventories, which consist of medical supplies, are stated at the lower of cost or market determined by using the first-in, first-out (FIFO) method.

PROPERTY AND EQUIPMENT

Property and equipment that is purchased is recorded at cost. Donated property and equipment is recorded at fair value at the date of donation. Depreciation is provided by using the straight-line method over the estimated useful lives.

Donations of property and equipment are reported as unrestricted support unless the donor has restricted the donated asset to a specific purpose. Assets donated with explicit restrictions regarding their use and contributions of cash that must be used to acquire property and equipment are reported as restricted support. Without donor stipulations regarding how long those donated assets must be maintained, the Organization reports expirations of donor restrictions when the donated assets are placed in service, reclassifying temporarily restricted net assets to unrestricted net assets at that time.

Additions and major renewals to property and equipment are capitalized. Maintenance and repairs are charged to expense when incurred. The cost and accumulated depreciation of assets sold or retired are removed from the respective accounts and any gain or loss is reflected as revenue or expense.

INCOME TAXES

The Organization is a not-for-profit organization as described in section 501(c)(3) of the Internal Revenue Code, and is exempt from federal and state income taxes except that unrelated business income is taxable. The Organization had no unrelated business income during the year ended June 30, 2010.

ADVERTISING

Advertising costs are expensed as incurred. Advertising costs were $90,275 for the year ended June 30, 2010.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

FUNCTIONAL EXPENSES

The costs of providing various programs and other activities have been summarized on a functional basis in the statement of activities and in the statement of functional expenses. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

COMPARATIVE INFORMATION

The financial statements include certain prior year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with accounting principles generally accepted in the United States of America. Accordingly, such information should be read in conjunction with the Organization's financial statements for the year ended June 30, 2009 from which the summarized information was derived.

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. The most significant estimates relate to third-party payor contractual allowances and the allowance for doubtful accounts. It is reasonably possible that these estimates will change in the near term due to one or more future confirming events. Actual results could differ from those estimates.

CONCENTRATIONS OF CREDIT RISK

Financial instruments which potentially subject the Organization to concentrations of credit risk consist primarily of cash and cash equivalents, investments and accounts receivable.

Cash and Cash Equivalents

The Organization maintains cash balances at several financial institutions, which routinely exceed federally insured amounts. The Organization maintains its deposits with high quality financial institutions, which the Organization believes limits this risk. As of June 30, 2010, the Organization had $555,000 of cash balances in excess of federally insured limits.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

CONCENTRATIONS OF CREDIT RISK (CONTINUED)

Cash and Cash Equivalents (continued)

In addition, the Organization maintains investment accounts with financial institutions that are not insured by the FDIC. These funds may be subject to insurance by SIPC, Securities Investor Protection Corporation, subject to various limitations. As of June 30, 2010, funds in these accounts in excess of SIPC limits totaled approximately $904,000.

The Organization believes that the credit risks associated with all investments are mitigated by the number, diversity and financial strength of its issuers.

Accounts Receivable

The Organization conducts business and extends credit based on an evaluation of third party payors' financial condition generally without requiring collateral. The Organization believes that credit risk with respect to accounts receivable is limited based upon the stature and diversity of the third-party payors with which they contract. The Organization monitors exposure to credit losses and maintains allowances for anticipated losses considered necessary under the circumstances.

Delinquent accounts receivable are charged against the allowance for doubtful accounts once uncollectibility has been determined. Accounts receivable are considered to be past due and placed on delinquent status based on contractual terms, as well as how frequently payments are received, on an individual account basis. The Organization has established an administrative formula based on the Organization's collection history to determine a reasonable allowance for doubtful accounts. The allowance for doubtful accounts was $93,000 at June 30, 2010.

NOTE 2 - UNCONDITIONAL PROMISES TO GIVE

Unconditional promises to give consist of the following:

United Way Allocation, for succeeding year activities	$ 52,359

NOTE 3 - INVESTMENTS

Investments were as follows:

	Cost	Fair Market Value
Corporate and other bonds	$ 499,256	$ 527,684
Mutual funds	231,835	240,241
Equity securities	144,874	152,445
Commodities	30,381	30,420
Real estate funds	10,740	10,048
Total Investments	$ 917,086	$ 960,838

The following schedule summarizes the investment income and its classification in the Statement of Activities:

	Unrestricted	Temporarily Restricted	Total
Interest and dividends	$ 33,645	$ 1	$ 33,646
Realized gains (losses)	56,467	--	56,467
Unrealized gains (losses)	21,567	--	21,567
Total Investment Income	$ 111,679	$ 1	$ 111,680

NOTE 4 - FAIR VALUE MEASUREMENTS

In fiscal year 2009, the Organization adopted ASC 820-10 *Fair Value Measurement and Disclosure* for non-recurring fair value measurements of its non-financial assets and liabilities. This guidance defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements. This standard establishes a three-level hierarchy for fair value measurements based upon the significant inputs used to determine fair value. Observable inputs are those which are obtained from market participants external to the company while unobservable inputs are generally developed internally, utilizing management's estimates, assumptions and specific knowledge of the assets/liabilities and related markets. The three levels are defined as follows:

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

LEVEL 1

Valuation is based on quoted prices in active markets for identical assets and liabilities.

LEVEL 2

Valuation is determined from quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar instruments in markets that are not active, or by model-based techniques in which all significant inputs are observable in the market.

LEVEL 3

Valuation is derived from model-based techniques inputs that are unobservable for the asset or liability. Unobservable inputs shall be used to measure fair value to the extent that observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity.

The following table sets forth by level, within the fair value hierarchy, the Organization's assets at fair value as of June 30, 2010:

	Level 1	Level 2	Level 3	Total
Corporate and other bonds	$ --	$ 527,684	$ --	$ 527,684
Mutual funds	240,241	--	--	240,241
Equity securities	152,445	--	--	152,445
Commodities	30,420	--	--	30,420
Real estate funds	10,048	--	--	10,048
	$ 433,154	$ 527,684	$ --	$ 960,838

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at June 30, 2010.

Corporate and other bonds: Evaluated prices using observable, market-based inputs such as bid evaluation, mid evaluation and ask/offer evaluation

Mutual funds: Valued at net asset value (NAV) of shares held by the Organization at year end

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

Equity securities: Valued at unadjusted quoted price in an active market or exchange for the last trade at the official close

Commodities: Valued at net asset value (NAV) of shares held by the Organization at year end

Real estate funds: Valued at net asset value (NAV) of shares held by the Organization at year end

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Organization believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

NOTE 5 - PROPERTY AND EQUIPMENT

	Amount	Estimated Useful Lives
Land	$ 300,880	-
Office furniture and equipment	1,062,130	5-7 years
Buildings and improvements	1,607,995	40 years
Automotive equipment	23,161	5 years
Software	392,000	7 years
	3,386,166	
Less accumulated depreciation	1,637,606	
Property and Equipment, Net	$ 1,748,560	

Depreciation expense was $159,572 for the year ended June 30, 2010.

NOTE 6 - DONATED SERVICES AND FACILITIES

The Organization pays for most services requiring specific expertise. However, a substantial number of unpaid volunteers have donated significant amounts of their time in the Organization's administration, fundraising efforts, solicitation of charitable contributions and other areas. Due to the specific requirements of accounting standards for not-for-profit organizations, the Organization was unable to recognize an amount for donated services in the accompanying statement of activities.

The North Broward Hospital District contributes the use of a building to the Organization. The Organization has recorded the estimated fair value rental of $65,000 for this facility for the year ended June 30, 2010. Such amount was recorded as revenue and as occupancy expense in the accompanying Statement of Activities (see Note 10).

NOTE 7 - GRANTS AND CONTRACTS FOR ORGANIZATION OPERATIONS

Funding agreements for services to be provided are entered into on an annual basis. The release of funds is subject to monies being made available by the federal government, the Florida legislature and Broward County. Either the grantors or the Organization may terminate these agreements with thirty days written notice.

Program expenditures made by the Organization are subject to additional audits and adjustments by grantor agencies. As a result of such audits, any disallowed claims, including amounts already collected, may constitute a liability in the future. The amount, if any, of expenditures which may be disallowed by the grantor cannot be determined at this time, although the Organization expects such amounts, if any, will not have a material adverse impact on the Organization.

NOTE 8 - BENEFIT PLANS

The Organization has a contributory benefit plan covering substantially all of its employees who meet certain age and length of service requirements. Employer contributions are determined annually by the Board of Directors subject to certain statutory limitations. The amount of the employer contribution is allocated among the participants in the same proportion that each participant's compensation bears to the aggregate compensation of all participants for the plan year. The Organization elected not to contribute to the plan for the year ended June 30, 2010.

NOTE 8 - BENEFIT PLANS (CONTINUED)

The Organization also maintains a Section 125 cafeteria plan for the benefit of its employees. No contribution is required by the Organization for this plan.

NOTE 9 - LINE OF CREDIT

The Organization, on May 17, 2006, executed a credit agreement in the amount of $1 million with Northern Trust. The available funding is secured by Northern Trust Bank of Florida N.A. Investment Management Account in the name of HospiceCare of Southeast Florida, Inc., as defined. The line bears interest at the prime rate minus 1% (2.25% at June 30, 2010) and is due on demand. A portion of this loan was used to purchase a building and land located in Fort Lauderdale, Florida at a total cost of approximately $550,000. The balance due on the line of credit as of June 30, 2010 was $938,994.

NOTE 10 - COMMITMENTS AND CONTINGENCIES

OPERATING LEASES

The Organization has operating leases for office space in Tavernier, Florida and Doral, Florida. The Organization has also obtained office space in Key West, Florida to house marketing supplies. The lease in Doral expired July 31, 2010 and was renewed through July 31, 2015. Monthly payments through July 31, 2010 were $7,991 and monthly payments through July 31, 2015 are $8,895. Monthly payments for the Tavernier space are $1,844 and the lease expires October 31, 2010. The Key West office space leased expired March 31, 2010 and the Organization has continued to lease on a month-to-month basis with monthly payments of $1,500 per month.

Minimum annual rentals are as follows:

For the Year Ending June 30,	Amount
2011	$ 113,616
2012	106,738
2013	106,738
2014	106,738
2015 and thereafter	115,633
Total	$ 549,463

NOTE 10 - COMMITMENTS AND CONTINGENCIES (CONTINUED)

OPERATING LEASES (CONTINUED)

Rent expense totaled $201,647 for the year ended June 30, 2010. Included in rent expense is $65,000 of donated rent (see Note 6).

IN-PATIENT HOSPITAL SERVICES

Each year, the Organization records an accrual for possible amounts due for patients' costs related to inpatient hospital services. No claim for payment has been made by the respective providers. The Organization has adopted a policy of reversing these costs at the time the statute of limitations for asserting a claim expires (4 years). The remaining estimated accrued liability for inpatient hospital costs at June 30, 2010 is $54,844, and is included in accrued expenses in the accompanying statement of financial position.

NOTE 11 - SPLIT-INTEREST AGREEMENTS

Split-interest agreements are arrangements between a donor and the Organization in which the donor contributes assets to the Organization in exchange for a promise from the Organization to pay the donor a fixed amount for a specified period of time. Assets received have been recognized at fair value, and an annuity payment liability has been recognized at the present value of the future cash flows projected to be paid. Unrestricted contribution revenue is recognized as the difference between these two amounts as the donor has placed no restrictions on the Organization's use of its portion of the assets. To calculate the present value of the charitable gift annuities, the 2004 U.S. Life Expectancy Tables (published by the National Center of Health Statistics) and discount rates noted below were used. The Organization has the following three agreements in place:

On December 30, 2002, the Organization entered into a split-interest agreement where the donor transferred assets with a fair market value of $10,000. Under conditions of the agreement, the Organization will pay the donor an amount of $98 monthly until the death of the donor. The discount rate used was 4%.

On August 10, 2005, the Organization entered into a split-interest agreement where the donor transferred assets with a fair market value of $25,000. Under conditions of the agreement, the Organization will pay the donor an amount of $706 quarterly until the death of the donor. The discount rate used was 4.8%.

NOTE 11 - SPLIT-INTEREST AGREEMENTS (CONTINUED)

On August 1, 2007, the Organization entered into a split-interest agreement where the donor transferred assets with a fair market value of $50,000. Under conditions of the agreement, the Organization will pay the donor an amount of $1,287 quarterly until the death of the donor. The discount rate used was 6.2%.

Possible future losses could be incurred for the annuity agreements if the rate earned on its investments is less than the discount rate used to value the liability at the inception of the agreement. The Organization could potentially deplete the investments of the gift annuity and, because typically the annuity is a general obligation of the Organization, have to make payments to the beneficiary from its own assets.

NOTE 12 – RESTATEMENT

The Organization, in August 2010, was notified of an adjustment to their Medicare cap based on a review pertaining to the period from November 1, 2008 to October 31, 2009. Based on the review, the Organization was notified that they owed $901,393 to Medicare. The adjustment was due to a difference in the number of fractional beneficiaries reported combined with a decrease in Medicare admissions for the 2009 period. This amount will be paid back to Medicare in the 2011 fiscal year through a recovery from Medicare payments. Of the total amount due to Medicare, $600,928 was applicable to the June 30, 2009 fiscal year end, and as such, the amounts previously reported in the 2009 financial statements have been restated for this amount as follows; accrued expenses were increased by $600,928, Medicare revenue was decreased by $600,928, and unrestricted net assets were decreased by $600,928.

NOTE 13 – SUBSEQUENT EVENT

Subsequent events have been evaluated through September 17, 2010, the date these financial statements were available to be issued.

Attachment H

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS e-*file* Signature Authorization for an Exempt Organization

For calendar year 2009, or fiscal year beginning 07/01 , 2009, and ending 06/30 , 20 10

▶ Do not send to the IRS. Keep for your records.

▶ See instructions on back.

OMB No. 1545-1878

2009

Name of exempt organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Name and title of officer: Esther Monzon-Aguirre, COO

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return for which you are filing this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a	**Form 990** check here ▶ [X]	**b Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	19842586.
2a	**Form 990-EZ** check here ▶ [ ]	**b Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a	**Form 1120-POL** check here ▶ [ ]	**b Total tax** (Form 1120-POL, line 22)	**3b**	
4a	**Form 990-PF** check here ▶ [ ]	**b Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a	**Form 8868** check here ▶ [ ]	**b Balance Due** (Form 8868, line 3c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2009 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** an indication of any refund offset, **(c)** the reason for any delay in processing the return or refund, and **(d)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize MARCUM, LLP (ERO firm name) to enter my PIN 3 3 1 3 1 (Enter five numbers, but do not enter all zeros) as my signature on the organization's tax year 2009 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2009 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Date ▶ 01/21/2011

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit EFIN followed by your five-digit self-selected PIN. 1 1 6 5 3 6 3 3 1 3 1 (do not enter all zeros)

I certify that the above numeric entry is my PIN, which is my signature on the 2009 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

For Paperwork Reduction Act Notice, see back of form.

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047

2009

Open to Public Inspection

A For the 2009 calendar year, or tax year beginning 07/01 **, 2009, and ending** 06/30 **, 20** 10

B Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Terminated ☐ Amended return ☐ Application pending

Please use IRS label or print or type. See Specific Instructions.

C Name of organization HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite

321 SE 18TH STREET

City or town, state or country, and ZIP + 4

FORT LAUDERDALE, FL 33316-2817

D Employer identification number 59-2120945

E Telephone number (954) 467-7423

G Gross receipts $ 21,202,763.

F Name and address of principal officer: SUSAN G. TELLI
321 SE 18TH STREET FORT LAUDERDALE, FL 33316

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) Are all affiliates included? ☐ Yes ☒ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c) (3) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.HOSPICECAREFLORIDA.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1981 **M** State of legal domicile: FL

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
HOSPICE MEDICALLY DIRECTED CARE FOR PATIENTS WHO ARE SUFFERING FROM A LIFE LIMITING ILLNESS AND SUPPORT FOR THEIR FAMILIES AND SIGNIFICANT OTHERS.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	11
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10
5	Total number of employees (Part V, line 2a)	5	354
6	Total number of volunteers (estimate if necessary)	6	250
7a	Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	
b	Net unrelated business taxable income from Form 990-T, line 34	7b	

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	873,736.	1,543,008.
	9	Program service revenue (Part VIII, line 2g)	19,149,823.	18,098,592.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	8,285.	90,111.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	240,383.	110,875.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	20,272,227.	19,842,586.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	416,978.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	11,634,274.	12,077,632.
	16 a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b	Total fundraising expenses, Part IX, column (D), line 25) ▶ 402,306.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	8,887,293.	7,987,710.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	20,521,567.	20,482,320.
	19	Revenue less expenses. Subtract line 18 from line 12	-249,340.	-639,734.
			Beginning of Year	**End of Year**
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	6,496,445.	6,766,882.
	21	Total liabilities (Part X, line 26)	3,426,945.	4,315,548.
	22	Net assets or fund balances. Subtract line 21 from line 20	3,069,500.	2,451,334.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer | Date

▶ Type or print name and title

Paid Preparer's Use Only

Preparer's signature ▶ | Date | Check if self-employed ▶ ☐ | Preparer's identifying number (see instructions) P00541422

Firm's name (or yours if self-employed), address, and ZIP + 4 ▶ MARCUM, LLP
ONE SE THIRD AVENUE, 10TH FLOOR MIAMI, FL 33131

EIN ▶ 11-1986323

Phone no. ▶ 305-995-9600

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☐ No

For Privacy Act and Paperwork Reduction Act Notice, see the separate instructions. *

Form **990** (2009)

JSA
9E1010 3.000

Part III Statement of Program Service Accomplishments

1 Briefly describe the organization's mission:
Attachment 3

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: _____) (Expenses $ _____ including grants of $ _____) (Revenue $ _____)

4b (Code: _____) (Expenses $ _____ including grants of $ _____) (Revenue $ _____)

4c (Code: _____) (Expenses $ _____ including grants of $ _____) (Revenue $ _____)

4d Other program services. (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶

Part IV **Checklist of Required Schedules**

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete Schedule B, Schedule of Contributors?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities? *If "Yes," complete Schedule C, Part II*	4	X	
5	**Sections 501(c)(4), 501(c)(5), and 501(c)(6) organizations.** Is the organization subject to the section 6033(e) notice and reporting requirement and proxy tax? *If "Yes," complete Schedule C, Part III*	5		
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? *If" Yes, "complete Schedule D, Part V*	10		X
11	Is the organization's answer to any of the following questions "Yes"? *If so, complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable*	11	X	
	• Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI.*			
	• Did the organization report an amount for investments—other-securitiesin Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII.*			
	• Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII.*			
	• Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX.*			
	• Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X.*			
	• Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48? *If "Yes," complete Schedule D, Part X.*			
12	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII.*	12	X	
12 A	Was the organization included in consolidated, independent audited financial statement for the tax year? *If "Yes," completing Schedule D, Parts XI, XII, and XIII is optional.* — 12A: Yes [ ] No [X]			
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E.*	13		X
14 a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? *If "Yes," complete Schedule F, Part I*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Part II.*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Part III*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20		X

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24 a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to question 25*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25 a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b	X	
c	An entity of which a current or former officer, director, trustee, or key employee of the organization (or a family member) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	34		X
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35		X
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38		X

Part V Statements Regarding Other IRS Filings and Tax Compliance

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096, Annual Summary and Transmittal of U.S. Information Returns. Enter -0- if not applicable	1a	23		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	354		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* this return. (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year covered by this return?	3a			X
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b			
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See the instructions for exceptions and filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to question 5a or 5b, did the organization file Form 8886-T, Disclosure by Tax-Exempt Entity Regarding Prohibited Tax Shelter Transaction?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?	6a		X	
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b		X	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization, during the year, receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	For all contributions of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	For contributions of cars, boats, airplanes, and other vehicles, did the organization file a Form 1098-C as required?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			

Part VI **Governance, Management, and Disclosure** *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body	1a	11		
b	Enter the number of voting members that are independent	1b	10		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its organizational documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a material diversion of the organization's assets?	5			X
6	Does the organization have members or stockholders?	6			X
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?	7a			X
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?	7b			X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9a			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Does the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?	10b		
11	Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?	11		X
11A	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Does the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Does the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this is done*	12c	X	
13	Does the organization have a written whistleblower policy?	13	X	
14	Does the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O. (See instructions.)			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a		X
b	If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ FL,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply.
☐ Own website ☐ Another's website [X] Upon request

19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ KACEY BENSON 321 SE 18TH STREET FORT LAUDERDALE, FL 33316
954-745-0710

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year. Use Schedule J-2 if additional space is needed.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if the organization did not compensate any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply): Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
MICHAEL G. ROBINSON, ESQ. PRESIDENT	1.00	X		X				0.	0	0.
JANET DAVIS VICE PRESIDENT	1.00	X		X				0.	0	0.
JOSE PAGAN TREASURER	1.00	X		X				0.	0	0.
MICHELLE DALAS, DDS SECRETARY	1.00	X		X				0.	0	0.
ANN LEE DIRECTOR	1.00	X						0.	0	0.
JAMES MURPHY, ESQ. DIRECTOR	1.00	X						0.	0	0.
DAVID RAY, ESQ. DIRECTOR	1.00	X						0.	0	0.
KARIN RHODES DIRECTOR	1.00	X						0.	0	0.
JOHN RUDDY DIRECTOR	1.00	X						0.	0	0.
NED SKIFF DIRECTOR	1.00	X						0.	0	0.
PATRICK NAUGHTON DIRECTOR	1.00	X						0.	0	0.
TOM PLACHTER DIRECTOR	1.00	X						0.	0	0.
SUSAN G. TELLI CHIEF EXECUTIVE OFFICER	40.00			X	X	X		198,969.	0	14,449.
KATHLEEN M. PALMER CHIEF FINANCIAL OFFICER	40.00			X		X		131,418.	0	12,968.
ESTHER MONZON-AGUIRRE CHIEF OPERATING OFFICER	40.00			X		X		115,583.	0	7,205.
DR. SREEN NARA MEDICAL DIRECTOR	40.00				X	X		247,216.	0	0.

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week	(C) Position (check all that apply): Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
PATRICIA BYRNES DIRECTOR OF ADMINISTRATION	40.00					X		106,135.	0.	22,209.
1b Total . . . . . ▶								799,321.	0.	56,831.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶ 5

		Yes	No
3 Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization.

(A) Name and business address	(B) Description of services	(C) Compensation
Attachment 4		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 19

Part VIII Statement of Revenue 59-2120945

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts					
1a	Federated campaigns 1a				
b	Membership dues 1b				
c	Fundraising events 1c				
d	Related organizations 1d				
e	Government grants (contributions) . . 1e				
f	All other contributions, gifts, grants, and similar amounts not included above . 1f 1,543,008.				
g	Noncash contributions included in lines 1a-1f: $ 1,046,067.				
h	**Total.** Add lines 1a-1f . . . . . ▶	1,543,008.			
Program Service Revenue	**Business Code**				
2a	MEDICARE	15,772,910.	15,772,910.		
b	PRIOR PERIOD ADJUSTMENT FOR UNCOLLECTABL	-600,929.	-600,929.		
c	MEDICAID	2,397,937.	2,397,937.		
d	INSURANCE	87,571.	87,571.		
e	PRIVATE PAY	388,917.	388,917.		
f	All other program service revenue	52,186.	52,186.		
g	**Total.** Add lines 2a-2f . . . . . ▶	18,098,592.			
Other Revenue					
3	Investment income (including dividends, interest, and other similar amounts) . . Attachment 5 . . . . . ▶	33,645.			33,645.
4	Income from investment of tax-exempt bond proceeds . . . ▶	0.			
5	Royalties . . . . . ▶	0.			
	(i) Real / (ii) Personal				
6a	Gross Rents.				
b	Less: rental expenses . . .				
c	Rental income or (loss) . .				
d	Net rental income or (loss) . . . . . ▶	0.			
	(i) Securities / (ii) Other				
7a	Gross amount from sales of assets other than inventory 1,324,890.				
b	Less: cost or other basis and sales expenses . . . . 1,268,424.				
c	Gain or (loss) . . . . . 56,466.				
d	Net gain or (loss) . . . . . ▶	56,466.			56,466.
8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . . a 209,574.				
b	Less: direct expenses . . . . . b 91,753.				
c	Net income or (loss) from fundraising events . ATCH. 6. ▶	117,821.			117,821.
9a	Gross income from gaming activities. See Part IV, line 19 . . . . . a				
b	Less: direct expenses . . . . . b				
c	Net income or (loss) from gaming activities . . . . . ▶	0.			
10a	Gross sales of inventory, less returns and allowances . . . . . a				
b	Less: cost of goods sold . . . . . b				
c	Net income or (loss) from sales of inventory . . . . . ▶	0.			
	Miscellaneous Revenue / **Business Code**				
11a	OTHER INCOME	927.	927.		
b	SPLIT INTEREST AGREEMENT	-7,873.	-7,873.		
c					
d	All other revenue				
e	**Total.** Add lines 11a-11d . . . . . ▶	-6,946.			
12	**Total Revenue.** See instructions . . . . . ▶	18,842,586.	18,091,646.		207,932.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21	0.			
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	416,978.	416,978.		
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	856,152.	247,216.	480,592.	128,344.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	9,266,223.	7,907,476.	1,183,204.	175,543.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	0.			
9 Other employee benefits	1,004,182.	883,576.	76,167.	44,439.
10 Payroll taxes	951,075.	774,590.	155,093.	21,392.
11 Fees for services (non-employees):				
a Management	0.			
b Legal	29,450.		29,450.	
c Accounting	24,000.		24,000.	
d Lobbying	0.			
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees	16,504.		16,504.	
g Other	6,097,312.	5,987,361.	109,951.	
12 Advertising and promotion	90,545.	33,477.	34,179.	22,889.
13 Office expenses	302,916.	152,190.	147,184.	3,542.
14 Information technology	261,730.	183,623.	78,107.	
15 Royalties	0.			
16 Occupancy	308,427.	13,572.	294,855.	
17 Travel	431,223.	384,455.	42,427.	4,341.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	26,011.	16,269.	9,033.	709.
20 Interest	23,061.		23,061.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	159,572.	130,422.	29,150.	
23 Insurance	171,742.		171,742.	
24 Other expenses. Itemize expenses not covered above. (Expenses grouped together and labeled miscellaneous may not exceed 5% of total expenses shown on line 25 below.)				
a LATE FEES	15,937.		15,937.	
b OTHER EXPENSES	29,280.	8,629.	19,544.	1,107.
c				
d				
e				
f All other expenses				
25 **Total functional expenses.** Add lines 1 through 24f	20,482,320.	17,139,834.	2,940,180.	402,306.
26 **Joint Costs.** Check here ▶ ☐ if following SOP 98-2. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		238,054.	1	683,454.
	2	Savings and temporary cash investments		554,039.	2	1,014,171.
	3	Pledges and grants receivable, net		52,181.	3	0.
	4	Accounts receivable, net		3,048,826.	4	2,216,894.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). Complete Part II of Schedule L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		40,082.	8	34,573.
	9	Prepaid expenses and deferred charges		36,008.	9	30,386.
	10 a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 3,386,165.			
	b	Less: accumulated depreciation	10b 1,637,605.	1,881,693.	10c	1,748,560.
	11	Investments - publicly traded securities ATCH 8		190,437.	11	152,445.
	12	Investments - other securities. See Part IV, line 11		429,478.	12	808,393.
	13	Investments - program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		25,647.	15	78,006.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		6,496,445.	16	6,766,882.
Liabilities	17	Accounts payable and accrued expenses		2,423,299.	17	1,912,984.
	18	Grants payable			18	
	19	Deferred revenue ATCH 9		0.	19	25,000.
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties ATCH 10		938,994.	23	938,994.
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities. Complete Part X of Schedule D		64,652.	25	1,438,570.
	26	**Total liabilities.** Add lines 17 through 25		3,426,945.	26	4,315,548.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		3,017,319.	27	2,398,975.
	28	Temporarily restricted net assets		52,181.	28	52,359.
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117, check here ▶ [ ] and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		3,069,500.	33	2,451,334.
	34	Total liabilities and net assets/fund balances		6,496,445.	34	6,766,882.

Part XI Financial Statements and Reporting

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a consolidated basis, separate basis, or both: ☒ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No 1545-0047

2009

Open to Public Inspection

Name of the organization
HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number
59-2120945

Part I **Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 [ ] A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 [ ] A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 [ ] A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 [ ] A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:

5 [ ] An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 [ ] A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 [ ] An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 [ ] A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 [X] An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 [ ] An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 [ ] An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a [ ] Type I **b** [ ] Type II **c** [ ] Type III - Functionally integrated **d** [ ] Type III - Other

e [ ] By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box . . . . . [ ]

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	**11g(i)**		
(ii) A family member of a person described in (i) above?	**11g(ii)**		
(iii) A 35% controlled entity of a person described in (i) or (ii) above?	**11g(iii)**		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
Total									

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule A (Form 990 or 990-EZ) 2009

JSA
9E1210 2.000

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) **12**

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2009 (line 6, column (f) divided by line 11, column (f)) . . . . . **14** %

15 Public support percentage from 2008 Schedule A, Part II, line 14 . . . . . **15** %

16a **33 1/3 % support test - 2009.** If the organization did not check the box on line 13, and line 14 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3 % support test - 2008.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2009.** If the organization did not check a box on line 13, 16a or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2008.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organzation meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ ☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 9 of Part I.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")	982,493.	1,031,501.	897,319.	873,736.	1,543,008.	5,328,057.
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose	16,405,895.	16,889,457.	21,366,862.	19,397,479.	18,098,529.	92,158,222.
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5	17,388,388.	17,920,958.	22,264,181.	20,271,215.	19,641,537.	97,486,279.
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						97,486,279.

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(f) Total
9 Amounts from line 6	17,388,388.	17,920,958.	22,264,181.	20,271,215.	19,641,537.	97,486,279.
10 a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	118,556.	76,316.	62,304.	8,285.	90,111.	355,572.
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b	118,556.	76,316.	62,304.	8,285.	90,111.	355,572.
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on					117,821.	117,821.
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) ATCH 1	182.	65.	123,513.	-7,273.	-6,946.	109,541.
13 **Total support.** (Add lines 9, 10c, 11, and 12.)	17,507,126.	17,997,339.	22,449,998.	20,272,227.	19,842,523.	98,069,213.

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2009 (line 8, column (f) divided by line 13, column (f))	15	99.41 %
16 Public support percentage from 2008 Schedule A, Part III, line 15	16	99.51 %

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2009** (line 10c, column (f) divided by line 13, column (f))	17	.36 %
18 Investment income percentage from **2008** Schedule A, Part III, line 17	18	.37 %

19 a **33 1/3 % support tests - 2009.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3 %, and line 17 is not more than 33 1/3 %, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶ [X]

b **33 1/3 % support tests - 2008.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3 %, and line 18 is not more than 33 1/3 %, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supplemental Information.** Complete this part to provide the explanation required by Part II, line 10; Part II, line 17a or 17b; or Part III, line 12. Provide any other additional information. See instructions

Attachment 1

SCHEDULE A, PART III - OTHER INCOME

DESCRIPTION	2005	2006	2007	2008	2009	TOTAL
OTHER INCOME	182.	65.	123,513.	0.	927.	124,687.
SPLIT INTEREST				-7,273.	-7,873.	-15,146.
TOTAL	182.	65.	123,513.	-7,273.	-6,946.	109,541.

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, 990-EZ, or 990-PF.

OMB No. 1545-0047

2009

Name of the organization
HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number
59-2120945

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[ ] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[X] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, aggregate contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not aggregate to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year . . . . . ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2 of its Form 990, or check the box on line H of its Form 990-EZ, or on line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF.

Name of organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Part I **Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	ELEANOR M. ZIMMERMAN CHARITABLE TRUST 321 SE 18TH STREET FORT LAUDERDALE, FL 33316-2817	$ 40,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2	ARLYNNE VOLLMUTH TRUST 6015 SOUTH VERDE TRAIL, #L-320 BOCA RATON, FL 33433	$ 156,400.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3	ROGERS FAMILY FOUNDATION 1401 E BROWARD BOULEVARD, SUITE 300 FORT LAUDERDALE, FL 33064	$ 40,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
4	UNITED WAY OF BROWARD COUNTY 1300 S ANDREWS AVENUE FORT LAUDERDALE, FL 33316	$ 72,338.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
5	ESTATE OF JOHN W. LLOY 3171 NORTHWEST 69TH STREET FORT LAUDERDALE, FL 33309	$ 1,046,067.	Person [X] Payroll [ ] Noncash [X] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number 59-2120945

Part II Noncash Property (see instructions)

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
5	BEQUESTED AT&T STOCK	$ 1,046,067.	11/25/2009

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ Complete if the organization is described below.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions

OMB No. 1545-0047

2009

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part VI, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
HOSPICECARE OF SOUTHEAST FLORIDA, INC.	59-2120945

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.

2 Political expenditures . . . . . ▶ $

3 Volunteer hours . . . . . .

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 . . . . . ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 . . ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? . . . . . ☐ Yes ☐ No

4a Was a correction made? . . . . . ☐ Yes ☐ No

b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities . . . . . ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities . . . . . ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b . . . . . ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? . . . . . ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which payments were made. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

JSA
9E1264 2 000

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group.
B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If these is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) Total
2a Lobbying non-taxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		X	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c	Media advertisements?		X	
d	Mailings to members, legislators, or the public?		X	
e	Publications, or published or broadcast statements?		X	
f	Grants to other organizations for lobbying purposes?		X	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	X		7,500.
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i	Other activities? If "Yes," describe in Part IV		X	
j	Total. Add lines 1c through 1i			7,500.
2 a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carryover lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) if BOTH Part III-A, lines 1 and 2 are answered "No" OR if Part III-A, line 3 is answered "Yes."**

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; and Part II-B, line 1i. Also, complete this part for any additional information.

Part IV **Supplemental Information** *(continued)*

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2009

Open to Public Inspection

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or pleasure)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIV, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIV, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III **Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets** *(continued)*

3 Using the organization's acquisition, acces sion, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV.

5 During the year, did the organization solici t or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? . . . . . ☐ Yes ☐ No

Part IV **Escrow and Custodial Arrangements.** Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custo dian or other intermediary for contributions or other assets not included on Form 990, Part X? . . . . . ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XI V and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? . . . . . ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XI V.

Part V **Endowment Funds.** Complete if organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current Year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

2 Provide the estimated percentage of the y ear end balance held as:

a Board designated or quasi-endowment ▶ _____ %
b Permanent endowment ▶ _____ %
c Term endowment ▶ _____ %

3a Are there endowment funds not in the pos session of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		
(ii) related organizations	3a(ii)		
b If "Yes" to 3a(ii), are the related organizati ons listed as required on Schedule R?	3b		

4 Describe in Part XIV the intended uses of t he organization's endowment funds.

Part VI **Investments - Land, Buildings, and Equipment.** See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		300,880.		300,880.
b Buildings				
c Leasehold improvements				
d Equipment				
e Other		3,085,285.	1,637,605.	1,447,680.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* . . . . . ▶				1,748,560.

Part VII **Investments - Other Securities.** See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
Financial derivatives		
Closely-held equity interests		
Other CORPORATE BONDS	527,684.	FMV
MUTUAL FUNDS	240,241.	FMV
COMMODITIES	30,420.	FMV
REAL ESTATE FUNDS	10,048.	FMV
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	808,393.	

Part VIII **Investments - Program Related.** See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 13.)* ▶		

Part IX **Other Assets.** See Form 990, Part X, line 15.

(a) Description	(b) Book value
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	

Part X **Other Liabilities.** See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Amount
Federal income taxes	
CAPITAL LEASE - SOFTWARE	0.
DUE TO MEDICARE	1,370,919.
OTHER LIABILITIES	67,651.
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	1,438,570.

2. FIN 48 Footnote. In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48.

Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	19,842,586.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	20,482,320.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	-639,734.
4	Net unrealized gains (losses) on investments	4	21,567.
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	600,929.
8	Other (Describe in Part XIV.)	8	
9	Total adjustments (net). Add lines 4 through 8	9	622,496.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-17,238.

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	20,621,835.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a	21,567.		
b	Donated services and use of facilities	2b	65,000.		
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	2d	692,682.		
e	Add lines 2a through 2d			2e	779,249.
3	Subtract line 2e from line 1			3	19,842,586.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV.)	4b			
c	Add lines 4a and 4b			4c	
5	Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)*			5	19,842,586.

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	20,639,073.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a	65,000.		
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIV.)	2d	91,753.		
e	Add lines 2a through 2d			2e	156,753.
3	Subtract line 2e from line 1			3	20,482,320.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV.)	4b			
c	Add lines 4a and 4b			4c	
5	Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)*			5	20,482,320.

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

See Page 5

Part XIV Supplemental Information *(continued)*

DESCRIPTION OF INVESTMENTS, LAND, BUILDING, AND EQUIPMENT

PART VI, LINE 1A - 1E

TOTAL BOOK VALUE OF ASSETS:

LAND -	$ 300,880
BUILDING-	$1,607,995
OFFICE FURNITURE/EQUIP.-	$1,062,129
AUTOMOTIVE EQUIPMENT -	$ 23,161
SOFTWARRE -	$ 392,000
TOTAL BOOK VALUE -	$3,386,165

BEGINING ACC. DEPRECIATION -	($ 1,478,034)
CURRENT YEAR DEPREACIATION -	($ 159,572)
ENDING ACC. DEPRECIATION -	($ 1,637,606)
NET BOOK VALUE OF ASSETS -	$ 1,748,559

RECONCILIATION

SCHEDULE D, PART XII, LINE 2D & PART XIII, LINE 2D

Direct fundraising expenses are shown separate from the fundraising revenue on the financial statements. On the Form 990 these amounts are shown net on page 9. ($91,753)

There was a prior period adjustment of Medicare revenue that is being reflected in the current fiscal year. ($600,929)

SCHEDULE G
(Form 990 or 990-EZ)
Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047
2009
Open To Public Inspection

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.
Employer identification number: 59-2120945

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a ☐ Mail solicitations
b ☐ Internet and email solicitations
c ☐ Phone solicitations
d ☐ In-person solicitations
e ☐ Solicitation of non-government grants
f ☐ Solicitation of government grants
g ☐ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
Total . . . . . ▶						

3 List all states in which the organization is registered or licensed to solicit funds or has been notified it is exempt from registration or licensing.

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Part II **Fundraising Events.** Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than $15,000 on Form 990-EZ, line 6a. List events with gross receipts greater than $5,000.

		(a) Event #1 HOSPICE REGATTA (event type)	(b) Event #2 GOLF TOURNAMENT (event type)	(c) Other Events 15 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	75,350.	37,660.	96,564.	209,574.
	2 Less: Charitable contributions				
	3 Gross income (line 1 minus line 2)	75,350.	37,660.	96,564.	209,574.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	1,850.	4,800.	2,500.	9,150.
	6 Rent/facility costs	1,760.	5,760.	7,500.	15,020.
	7 Food and beverages	21,940.	4,860.	9,500.	36,300.
	8 Entertainment	500.		2,000.	2,500.
	9 Other direct expenses	15,070.	2,430.	11,283.	28,783.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(91,753.)
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				117,821.

Part III **Gaming.** Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				( )
	8 Net gaming income summary. Combine line 1, column d, and line 7 ▶				

			Yes	No
9	Enter the state(s) in which the organization operates gaming activities:			
a	Is the organization licensed to operate gaming activities in each of these states?	9a		
b	If "No," explain:			
10 a	Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year?	10a		
b	If "Yes," explain:			
11	Does the organization operate gaming activities with nonmembers?	11		
12	Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?	12		

			Yes	No
13	Indicate the percentage of gaming activity operated in:			
a	The organization's facility	13a %		
b	An outside facility	13b %		
14	Enter the name and address of the person who prepares the organization's gaming/special events books and records:			
	Name ▶			
	Address ▶			
15 a	Does the organization have a contract with a third party from whom the organization receives gaming revenue?	15a		
b	If "Yes," enter the amount of gaming revenue received by the organization ▶$ _____ and the amount of gaming revenue retained by the third party ▶$ _____.			
c	If "Yes," enter name and address of the third party:			
	Name ▶			
	Address ▶			
16	Gaming manager information:			
	Name ▶			
	Gaming manager compensation ▶$ _____			
	Description of services provided ▶			
	☐ Director/officer ☐ Employee ☐ Independent contractor			
17	Mandatory distributions:			
a	Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?	17a		
b	Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $			

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.

OMB No. 1545-0047

2009

Open to Public Inspection

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Governments and Organizations in the United States.

Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Use Part IV and Schedule I-1 (Form 990) if additional space is needed . . . ▶ [ ]

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance

2 Enter total number of section 501(c)(3) and government organizations . . . ▶

3 Enter total number of other organizations . . . ▶

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990.

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Use Part IV and Schedule I-1 (Form 990) if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
HOSPICE CARE FOR UNDERPRIVILEGED	45	0.	416,978.	FMV	HOSPICE SERVICES

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

ASSISTANCE PROCEDURES

SCHEDULE I, PART 1, LINE 2

Hospice Care has licensed clinical social workers who assess the ability for an individual to pay for the services either through Medicaid, Medicare, private insurance or out of pocket. Individuals who do not qualify for any of these are provide Hospice care services at no cost.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.

▶ Attach to Form 990. ▶See separate instructions.

OMB No. 1545-0047

2009

Open to Public Inspection

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel ☐ Housing allowance or residence for personal use			
	☐ Travel for companions ☐ Payments for business use of personal residence			
	☐ Tax indemnification and gross-up payments ☐ Health or social club dues or initiation fees			
	☐ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on line 1a is checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply.			
	☐ Compensation committee ☐ Written employment contract			
	☐ Independent compensation consultant ☒ Compensation survey or study			
	☐ Form 990 of other organizations ☒ Approval by the board or compensation committee			
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regs. section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990.

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** Use Schedule J-1 if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
SUSAN G. TELLI	(i)	183,369.	0.	15,600.	0.	14,449.	213,418.	215,935.
	(ii)	0.	0.	0.	0.	0.	0.	0.
DR. SREEN NARA	(i)	247,216.	0.	0.	0.	0.	247,216.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 4c, 5a, 5b, 6a, 6b, 7, and 8. Also complete this part for any additional information.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047
2009
Open To Public Inspection

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.
Employer identification number: 59-2120945

Part I Excess Benefit Transacations (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 (a) Name of disqualified person	(b) Description of transaction	(c) Corrected? Yes	No

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

(a) Name of interested person and purpose	(b) Loan to or from the organization? To	From	(c) Original principal amount	(d) Balance due	(e) In default? Yes	No	(f) Approved by board or committee? Yes	No	(g) Written agreement? Yes	No
Total . . . . . ▶ $										

Part III Grants or Assistance Benefitting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount and type of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	No
LLOYD RHODES	HUSBAND OF BOARD MEMBER	1,068,010.	INSURANCE BROKER - DOES NOT		X
N/A			RECEIVE PAYMENTS FROM HOSPICE.		
N/A			PAYMENTS ARE PAID DIRECTLY TO		
N/A			INSURANCE COMPANY, SEE SCH. O		

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule L (Form 990 or 990-EZ) 2009

JSA
9E1297 2.000

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.

OMB No. 1545-0047

2009

Open To Public Inspection

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions	(c) Revenues reported on Form 990, Part VIII, line 1g	(d) Method of determining revenues
1	Art-Works of art				
2	Art-Historical treasures				
3	Art-Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities-Publicly traded	X	1	1,046,067.	FMV on 11/25/2009
10	Securities-Closely held stock				
11	Securities-Partnership, LLC, or trust interests				
12	Securities-Miscellaneous				
13	Qualified conservation contribution-Historic structures				
14	Qualified conservation contribution-Other				
15	Real estate-Residential				
16	Real estate-Commercial				
17	Real estate-Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶( )				
26	Other ▶( )				
27	Other ▶( )				
28	Other ▶( )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement 29 0

			Yes	No
30 a	During the year, did the organization receive by contribution any property reported in Part I, line 1-28 that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a		X
b	If "Yes," describe the arrangement in Part II.			
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?	31		X
32 a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a		X
b	If "Yes," describe in Part II.			
33	If the organization did not report revenues in column (c) for a type of property for which column (a) is checked, describe in Part II.			

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule M (Form 990) 2009

JSA
9E1298 2.000

Part II **Supplemental Information.** Complete this part to provide the information required by Part I, lines 30b, 32b, and 33. Also complete this part for any additional information.

SCHEDULE O (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990

Complete to provide information for responses to specific questions on Form 990 or to provide any additional information.
▶ Attach to Form 990.

OMB No 1545-0047

2009

Open to Public Inspection

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Attachment 2

POLICIES - CONFLICT OF INTEREST

990 PAGE 6, PART VI, SECTION B, LINE 12C

ALL OFFICERS, DIRECTORS AND TRUSTEES ARE QUESTIONED DURING THE ANNUAL FINANCIAL AUDIT AND ASKED TO DISCLOSE ANY CONFLICTS OF INTEREST.

POLICIES - COMPENSATION

990 PAGE 6, PART VI, SECTION B, LINE 15A & 15B

EACH YEAR THE BOARD PERFORMS A COMPARATIVE SALARY ANALYSIS BY REVIEWING PERFORMANCE APPRAISALS AND CONSIDERATION FOR LENTGH OF SERVICE TO THE ORGANIZATION FOR ALL OFFICERS AND KEY EMPLOYEES.

DISCLOSURE - DOCUMENTS

990 PAGE 6, PART VI, PART C, LINE 19

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

GOVERNING BODY AND MANG. - 990 REVIEW

990 PAGE 6, PART VI, SECTION B, LINE 11A

PRIOR TO FILING, THE FORM 990 IS REVIEWED BY THE CHIEF FINANCIAL OFFICER FOR ACCURACY.

TRANSACTIONS WITH RELATED PERSONS

SCHEDULE L, PART

Lloyd Rhodes is the Insurance BROKER for Hospice Care. The insurance

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Attachment 2 (Cont'd)

premiums paid by Hospice Care do not go to Mr. Rhodes; rather, they are paid to the insurance companies, COVENTRY AND MEDLIFE. The insurance companies then pay the agreed upon commission, between the insurance company and Mr. Rhodes, to Mr. Rhodes.

Attachment 3

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

HOSPICE MEDICALLY DIRECTED CARE FOR PATIENTS WHO ARE SUFFERING FROM A LIFE LIMITING ILLNESS AND SUPPORT FOR THEIR FAMILIES AND SIGNIFICANT OTHERS. HOSPICE SERVICES INCLUDE PHYSICIAN, NURSING, COUNSELING, AND SPIRITUAL CARE FOR PATIENTS TO MANAGE PAIN AND SYMPTOMS CAUSED BY CANCER AND OTHER END STAGE DEGENERATIVE DISEASES, AND FAMILY BEREAVEMENT SERVICES FOLLOWING DEATH.

Attachment 4

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
VISTA HEALTH PLAN PO Box 30741 TAMPA, FL 33630	HEALTH INSURANCE	1,029,309.
MEDEX, USA INC. 5400 NW 35th Terrace, # 101 FT. LAUDERDALE, FL 33309	MEDICAL SUPPLY	873,054.
ONEPOINT PHARMACY PO Box 27385 TEMPE, AZ 85285	Pharmaceutical	782,087.
JAD MEDICAL SUPPLY 10840 NW 138 Street HIALEAH, FL 33018	Medical Equipment	740,708.
AFFORDABLE MEDICAL AQUIPMENT	Medical Equipment	509,643.

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Attachment 4 (Cont'd)

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
4255 West Commercial Blvd. TAMARAC, FL 33319		
TOTAL COMPENSATION		3,934,801.

Attachment 5

FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
INTEREST AND DIVIDENDS	33,645.			33,645.
TOTALS	33,645.			33,645.

Attachment 6

FORM 990, PART VIII - FUNDRAISING EVENTS

DESCRIPTION	GROSS INCOME	DIRECT EXPENSES	NET INCOME
HOSPICE REGATTA	75,350.	41,120.	34,230.
GOLF TOURNAMENT	37,660.	17,850.	19,810.
VARIOUS SMALL EVENTS	96,564.	32,783.	63,781.
TOTALS	209,574.	91,753.	117,821.

Attachment 7

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Attachment 7 (Cont'd)

FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

DESCRIPTION	ENDING BOOK VALUE
PREPAID EXPENSES	30,386.
TOTALS	30,386.

Attachment 8

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

DESCRIPTION	ENDING BOOK VALUE	COST OR FMV
EQUITY SECURITIES	152,445.	FMV
TOTALS	152,445.	

Attachment 9

FORM 990, PART X - DEFERRED REVENUE

DESCRIPTION	ENDING BOOK VALUE
DEFERRED REVENUE	25,000.
TOTALS	25,000.

Attachment 10

FORM 990, PART X - SECURED MORTGAGES AND NOTES PAYABLE

LENDER: NORTHERN TRUST - LINE OF CREDIT
ORIGINAL AMOUNT: 1,000,000.
INTEREST RATE: 0.022500
DATE OF NOTE: 05/17/2006
MATURITY DATE: 06/30/2009
REPAYMENT TERMS: PAYMENT IS DUE ON DEMAND
SECURITY PROVIDED: USED TO PURCHASE LAND AND BUILDING
PURPOSE OF LOAN: LINE OF CREDIT

BEGINNING BALANCE DUE .....

Name of the organization: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Attachment 10 (Cont'd)

	938,994.
ENDING BALANCE DUE	938,994.
TOTAL BEGINNING MORTGAGES AND OTHER NOTES PAYABLE	938,994.
TOTAL ENDING MORTGAGES AND OTHER NOTES PAYABLE	938,994.

SCHEDULE D
(Form 1041)

Department of the Treasury
Internal Revenue Service

Capital Gains and Losses

▶ Attach to Form 1041, Form 5227, or Form 990-T. See the instructions for Schedule D (Form 1041) (also for Form 5227 or Form 990-T, if applicable).

OMB No. 1545-0092

2009

Name of estate or trust: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Note: *Form 5227 filers need to complete* ***only*** *Parts I and II.*

Part I Short-Term Capital Gains and Losses - Assets Held One Year or Less

(a) Description of property (Example: 100 shares 7% preferred of "Z" Co.)	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Sales price	(e) Cost or other basis (see page 4 of the instructions)	(f) Gain or (loss) for the entire year Subtract (e) from (d)
1a					

b Enter the short-term gain or (loss), if any, from Schedule D-1, line 1b	1b	
2 Short-term capital gain or (loss) from Forms 4684, 6252, 6781, and 8824	2	
3 Net short-term gain or (loss) from partnerships, S corporations, and other estates or trusts	3	
4 Short-term capital loss carryover. Enter the amount, if any, from line 9 of the 2008 Capital Loss Carryover Worksheet	4	( )
5 **Net short-term gain or (loss).** Combine lines 1a through 4 in column (f). Enter here and on line 13, column (3) on the back ▶	5	

Part II Long-Term Capital Gains and Losses - Assets Held More Than One Year

(a) Description of property (Example: 100 shares 7% preferred of "Z" Co.)	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Sales price	(e) Cost or other basis (see page 4 of the instructions)	(f) Gain or (loss) for the entire year Subtract (e) from (d)
6a					

b Enter the long-term gain or (loss), if any, from Schedule D-1, line 6b	6b	56,466.
7 Long-term capital gain or (loss) from Forms 2439, 4684, 6252, 6781, and 8824	7	
8 Net long-term gain or (loss) from partnerships, S corporations, and other estates or trusts	8	
9 Capital gain distributions	9	
10 Gain from Form 4797, Part I	10	
11 Long-term capital loss carryover. Enter the amount, if any, from line 14 of the 2008 Capital Loss Carryover Worksheet	11	( )
12 **Net long-term gain or (loss).** Combine lines 6a through 11 in column (f). Enter here and on line 14a, column (3) on the back ▶	12	56,466.

For Paperwork Reduction Act Notice, see the Instructions for Form 1041.

Schedule D (Form 1041) 2009

JSA
9F1210 2.000

Part III Summary of Parts I and II

Caution: *Read the instructions* ***before*** *completing this part.*

		(1) Beneficiaries' (see page 5)	(2) Estate's or trust's	(3) Total
13 **Net short-term gain or (loss)**	13			
14 **Net long-term gain or (loss):**				
a Total for year	14a			56,466.
b Unrecaptured section 1250 gain (see line 18 of the wrksht.)	14b			
c 28% rate gain	14c			
15 **Total net gain or (loss).** Combine lines 13 and 14a ▶	15			56,466.

Note: *If line 15, column (3), is a net gain, enter the gain on Form 1041, line 4 (or Form 990-T, Part I, line 4a). If lines 14a and 15, column (2), are net gains, go to Part V, and* ***do not*** *complete Part IV. If line 15, column (3), is a net loss, complete Part IV and the* ***Capital Loss Carryover Worksheet*** *as necessary.*

Part IV Capital Loss Limitation

16 Enter here and enter as a (loss) on Form 1041, line 4 (or Form 990-T, Part I, line 4c, if a trust), the **smaller** of:

a The loss on line 15, column (3) **or** b $3,000 . . . 16 ( )

Note: *If the loss on line 15, column (3), is more than $3,000,* **or** *if Form 1041, page 1, line 22 (or Form 990-T, line 34), is a loss, complete the* ***Capital Loss Carryover Worksheet*** *on page 7 of the instructions to figure your capital loss carryover.*

Part V Tax Computation Using Maximum Capital Gains Rates

Form 1041 filers. Complete this part **only** if both lines 14a and 15 in column (2) are gains, or an amount is entered in Part I or Part II and there is an entry on Form 1041, line 2b(2), **and** Form 1041, line 22, is more than zero.

Caution: *Skip this part and complete the worksheet on page 8 of the instructions if:*

- *Either line 14b, col. (2) or line 14c, col. (2) is more than zero, or*
- *Both Form 1041, line 2b(1), and Form 4952, line 4g are more than zero.*

Form 990-T trusts. Complete this part **only** if both lines 14a and 15 are gains, or qualified dividends are included in income in Part I of Form 990-T, **and** Form 990-T, line 34, is more than zero. Skip this part and complete the worksheet on page 8 of the instructions if either line 14b, col. (2) or line 14c, col. (2) is more than zero.

17	Enter taxable income from Form 1041, line 22 (or Form 990-T, line 34)			17	
18	Enter the **smaller** of line 14a or 15 in column (2) but not less than zero	18			
19	Enter the estate's or trust's qualified dividends from Form 1041, line 2b(2) (or enter the qualified dividends included in income in Part I of Form 990-T)	19			
20	Add lines 18 and 19	20			
21	If the estate or trust is filing Form 4952, enter the amount from line 4g; otherwise, enter -0- ▶	21			
22	Subtract line 21 from line 20. If zero or less, enter -0-			22	
23	Subtract line 22 from line 17. If zero or less, enter -0-			23	
24	Enter the **smaller** of the amount on line 17 or $2,300			24	
25	Is the amount on line 23 equal to or more than the amount on line 24? ☐ **Yes.** Skip lines 25 and 26; go to line 27 and check the "No" box. ☐ **No.** Enter the amount from line 23			25	
26	Subtract line 25 from line 24			26	
27	Are the amounts on lines 22 and 26 the same? ☐ **Yes.** Skip lines 27 thru 30; go to line 31. ☐ **No.** Enter the **smaller** of line 17 or line 22			27	
28	Enter the amount from line 26 (If line 26 is blank, enter -0-)			28	
29	Subtract line 28 from line 27			29	
30	Multiply line 29 by 15% (.15)				30
31	Figure the tax on the amount on line 23. Use the 2009 Tax Rate Schedule for Estates and Trusts (see the Schedule G instructions in the instructions for Form 1041)				31
32	Add lines 30 and 31				32
33	Figure the tax on the amount on line 17. Use the 2009 Tax Rate Schedule for Estates and Trusts (see the Schedule G instructions in the instructions for Form 1041)				33
34	**Tax on all taxable income.** Enter the **smaller** of line 32 or line 33 here and on Form 1041, Schedule G, line 1a (or Form 990-T, line 36)				34

Name of estate or trust as shown on Form 1041. Do not enter name and employer identification number if shown on the other side: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Employer identification number: 59-2120945

Part II Long-Term Capital Gains and Losses - Assets Held More Than One Year

(a) Description of property (Example: 100 sh. 7% preferred of "Z" Co.)	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Sales price (see page 4 of the instructions)	(e) Cost or other basis (see page 4 of the instructions)	(f) Gain or (loss) Subtract (e) from (d)
6a SALE OF AT&T STOCK BEQUEST BY JOHN LIOY	11/25/2009	12/30/2009	1,099,788.	1,046,067.	53,721.
SALE OF SECURITIES - FIDELITY	VARIOUS	VARIOUS	225,102.	222,357.	2,745.

6b Total. Combine the amounts in column (f). Enter here and on Schedule D, line 6b . . . . . 56,466.

Form **4562**

Department of the Treasury
Internal Revenue Service (99)

Depreciation and Amortization
(Including Information on Listed Property)

▶ See separate instructions. ▶ Attach to your tax return.

OMB No. 1545-0172

2009

Attachment Sequence No. **67**

Name(s) shown on return: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

Identifying number: 59-2120945

Business or activity to which this form relates: GENERAL DEPRECIATION

Part I **Election To Expense Certain Property Under Section 179**

Note: *If you have any listed property, complete Part V before you complete Part I.*

1	Maximum amount. See the instructions for a higher limit for certain businesses	1	
2	Total cost of section 179 property placed in service (see instructions)	2	
3	Threshold cost of section 179 property before reduction in limitation (see instructions)	3	
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	

6	(a) Description of property	(b) Cost (business use only)	(c) Elected cost

7	Listed property. Enter the amount from line 29	7	
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7	8	
9	Tentative deduction. Enter the **smaller** of line 5 or line 8	9	
10	Carryover of disallowed deduction from line 13 of your 2008 Form 4562	10	
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions)	11	
12	Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11	12	
13	Carryover of disallowed deduction to 2010. Add lines 9 and 10, less line 12 ▶	13	

Note: *Do not use Part II or Part III below for listed property. Instead, use Part V.*

Part II **Special Depreciation Allowance and Other Depreciation** (Do not include listed property.) (See instructions.)

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	

Part III **MACRS Depreciation** (Do not include listed property.) (See instructions.)

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2009	17	158,205.
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ▶ ☐		

Section B - Assets Placed in Service During 2009 Tax Year Using the General Depreciation System

(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only - see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19a 3-year property	See Detail					
b 5-year property		26,438.	5.000	HY	200DB	1,366.
c 7-year property						
d 10-year property						
e 15-year property						
f 20-year property						
g 25-year property			25 yrs.		S/L	
h Residential rental property			27.5 yrs.	MM	S/L	
			27.5 yrs.	MM	S/L	
i Nonresidential real property			39 yrs.	MM	S/L	
				MM	S/L	

Section C - Assets Placed in Service During 2009 Tax Year Using the Alternative Depreciation System

20a Class life					S/L	
b 12-year			12 yrs.		S/L	
c 40-year			40 yrs.	MM	S/L	

Part IV **Summary** (See instructions.)

21	Listed property. Enter amount from line 28	21	
22	**Total.** Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations - see instructions	22	159,571.
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	

JSA **For Paperwork Reduction Act Notice, see separate instructions.**

Part V **Listed Property** (Include automobiles, certain other vehicles, cellular telephones, certain computers, and property used for entertainment, recreation, or amusement.)

Note: *For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete* **only** *24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.*

Section A - Depreciation and Other Information (Caution: *See the instructions for limits for passenger automobiles.*)

24a Do you have evidence to support the business/investment use claimed? Yes No 24b If "Yes," is the evidence written? Yes No

(a) Type of property (list vehicles first)	(b) Date placed in service	(c) Business/ investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation deduction	(i) Elected section 179 cost
25 Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50% in a qualified business use (see instructions)						25		
26 Property used more than 50% in a qualified business use:								
		%						
		%						
		%						
27 Property used 50% or less in a qualified business use:								
		%				S/L -		
		%				S/L -		
		%				S/L -		
28 Add amounts in column (h), lines 25 through 27. Enter here and on line 21, page 1						28		
29 Add amounts in column (i), line 26. Enter here and on line 7, page 1							29	

Section B - Information on Use of Vehicles

Complete this section for vehicles used by a sole proprietor, partner, or other "more than 5% owner," or related person. If you provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles.

	(a) Vehicle 1		(b) Vehicle 2		(c) Vehicle 3		(d) Vehicle 4		(e) Vehicle 5		(f) Vehicle 6	
30 Total business/investment miles driven during the year (do not include commuting miles)												
31 Total commuting miles driven during the year												
32 Total other personal (noncommuting) miles driven												
33 Total miles driven during the year. Add lines 30 through 32												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
34 Was the vehicle available for personal use during off-duty hours?												
35 Was the vehicle used primarily by a more than 5% owner or related person?												
36 Is another vehicle available for personal use?												

Section C - Questions for Employers Who Provide Vehicles for Use by Their Employees

Answer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who **are not** more than 5% owners or related persons (see instructions).

	Yes	No
37 Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		
38 Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1% or more owners		
39 Do you treat all use of vehicles by employees as personal use?		
40 Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?		
41 Do you meet the requirements concerning qualified automobile demonstration use? (See instructions.)		

Note: *If your answer to 37, 38, 39, 40, or 41 is "Yes," do not complete Section B for the covered vehicles.*

Part VI **Amortization**

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
42 Amortization of costs that begins during your 2009 tax year (see instructions):					
43 Amortization of costs that began before your 2009 tax year				43	
44 **Total.** Add amounts in column (f). See the instructions for where to report				44	

HOSPICECARE OF SOUTHEAST FLORIDA, INC.

2009

59-2120345

Description of Property

GENERAL DEPRECIATION

DEPRECIATION

Asset description	Date placed in service	Unadjusted Cost or basis	Bus. %	179 exp. reduction in basis	Basis Reduction	Basis for depreciation	Beginning Accumulated depreciation	Ending Accumulated depreciation	Method	Conv.	Life	ACRS class	MACRS class	Current-year 179 expense	Current-year depreciation
LAND	VAR	300,880.	100.000												
OTHER FIXED ASSETS	VAR	2,974,807.	100.000			2,974,807.	1,441,063.	1,594,921.	SL	MM			39		153,858.
OTHER FIXED ASSETS	VAR	84,040.	100.000			84,040.	36,971.	41,318.	200DB	HY			5		4,347.
OTHER FIXED ASSETS	VARIOUS	26,438.	100.000			26,438.		1,366.	200DB	HY			5		1,366.
Less: Retired Assets															
Subtotals		3,386,165.				3,085,285.	1,478,034.	1,637,605.							159,571.

Listed Property

Less: Retired Assets															
Subtotals															
TOTALS		3,386,165.				3,085,285.	1,478,034.	1,637,605.							159,571.

AMORTIZATION

Asset description	Date placed in service	Cost or basis	Accumulated amortization	Ending Accumulated amortization	Code	Life	Current-year amortization
TOTALS							

*Assets Retired

JSA
9X9024 1.000

Attachment I

Current Hospice Fee Schedule
2010 – 2011

Per Diem Charges (All Inclusive)*	HCPCS Code	2010 – 2011 Rates
Routine Home Care	651	$157.00
Continuous Crisis Care**	652	$912.00
Respite Care	655	$168.00
Inpatient Acute Care	656	$688.00
Hospice Residential Room and Board***		$125.00

* All inclusive Rates cover medical costs as outlines in the Hospice Plan of Care and directly related to the terminal diagnosis. Physician charges include visits by Hospice Medical Directors and Physicians only.

** Continuous Crisis Care is billed at $38.00 per hour, with care requirements determined on a case by case basis as outlined in the Hospice Plan of Care.

*** Plus Hospice Care Per Diem, unless covered by Medicare, Medicaid or other Insurance.

309 SE 18 Street, Fort Lauderdale, FL 33316
(954) 467-7423 • (800) HOSPICE • Fax: (954) 524-6067

8405 NW 53 Street, Ste. A-200, Doral, FL 33166
(305) 599-7755 • (800) HOSPICE • Fax: (305) 599-3588

91256 Overseas Highway, Tavernier, FL, 33070
(305) 852-3223 • (800) HOSPICE • Fax: (305) 852-8223

www.hospicecareflorida.org

Joint Commission on Accreditation of Healthcare Organizations

United Way of Broward County

Certified by Medicare & Medicaid

Attachment J

Internal Revenue Service

Department of the Treasury

P. O. Box 2508
Cincinnati, OH 45201

Date: September 25, 2001

Person to Contact:
Jeremy L. Vogelpohl 31-03888
Customer Service Representative
Toll Free Telephone Number:
8:00 a.m. to 9:30 p.m. EST
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
59-2120945

Hospice Care of Southeast Florida, Inc.
309 S.E. 18th Street
Fort Lauderdale, FL 33316-2817

Dear Sir or Madam:

This is in response to the amendment to your organization's Articles of Incorporation filed with the state on January 29, 2001. We have updated our records to reflect the name change as indicated above.

Our records indicate that a determination letter issued on January 6, 1982 granted your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in effect.

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in section 509(a)(2).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Hospice Care of Southeast Florida, Inc.
59-2120945

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

The law requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. If your organization had a copy of its application for recognition of exemption on July 15, 1987, it is also required to make available for public inspection a copy of the exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. You can charge only a reasonable fee for reproduction and actual postage costs for the copied materials. The law does not require you to provide copies of public inspection documents that are widely available, such as by posting them on the Internet (World Wide Web). You may be liable for a penalty of $20 a day for each day you do not make these documents available for public inspection (up to a maximum of $10,000 in the case of an annual return).

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms your organization's exempt status.

Sincerely,

John E. Ricketts

John E. Ricketts, Director, TE/GE
Customer Account Services

Attachment M

HospiceCare of Southeast Florida

Fort Lauderdale, FL

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

May 9, 2009

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #5327
Print/Reprint Date: 7/28/09

Mark Chassin, M.D.
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Attachment N

CERTIFICATE #: 1035

LICENSE #: 5012096

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION

DIVISION OF HEALTH QUALITY ASSURANCE

HOSPICE

LICENSED

This is to confirm that HOSPICECARE OF SOUTHEAST FLORIDA INC has complied with rules and regulations adopted by the State of Florida, Agency for Health Care Administration, authorized in Chapter 400, Part IV, Florida Statutes and is authorized to operate the following:

HOSPICECARE OF SOUTHEAST FLORIDA, INC.
309 SE 18TH STREET
FORT LAUDERDALE, FL 33316-2817
BROWARD COUNTY
in the following counties:
BROWARD, DADE, MONROE

Branch Offices:
*8405 N W 53rd Street, Suite A200, Doral, FL 33166

Residential Facilities:
*1727 S E 4th Avenue, Fort Lauderdale, FL 33316 (8 beds)

EFFECTIVE DATE: 01/01/2011

EXPIRATION DATE: 12/31/2012

Elizabeth Dudek

Interim Secretary, Agency for Health Care Administration

Attachment D

HospiceCare of Southeast Florida, Inc.

Equal Employment Opportunity /Affirmative Action				
Effective Date:6/02	Responsibility Human Resources	Revised/Reviewed: 5/93, 4/94, 9/95, 2/99, 12/00, 2/02, 4/04,1/10, 4/10	Policy Number: 4.100	Page 1 of 2
Application/Location: All Locations		Approved by:	Approved by:	

I. Policy:

It is the policy of HospiceCare of Southeast Florida, Inc. to provide equal opportunity in employment to all employees and applicants for employment. No person will be discriminated against in employment because of race, religion, creed, color, sex, age, national origin, disability, marital status, veteran's status, sexual orientation, political affiliation or other protected class.

II. Standard of Practice:

1. This agency is an equal opportunity employer involved in recruiting, retaining and promoting the most qualified person for the job. Positions may be posted, advertised for, or recruited for, as the needs arise. Never will an employment decision be based on a person's race, color, sex, religion, creed, national origin, marital status, age, physical or mental disability, veteran's status or political affiliation .
2. This policy applies to all terms, conditions, and privileges of employment and all policies of the agency, including hiring, introductory period, training, orientation, placement and employee development, promotion, transfer, compensation, benefits, employee facilities and termination.
3. Any communication from an applicant for employment, an employee, a government agency, or an attorney concerning any equal employment opportunity matter should be referred to the Director of Human Resources.
4. While overall responsibility for implementing this policy is assigned to the Human Resources Director, an effective equal employment opportunity program cannot be achieved without the support of supervisory personnel and employees at all levels. Any employee who believes they have suffered from discrimination has a responsibility to report this concern to their supervisor or the Director of Human Resources.
5. All vendors, independent contractors, subcontractors, referral sources, patients, and others doing business with the Agency will be informed of the organization's adherence to equal opportunity principles. Advertising for prospective staff members will identify HospiceCare of Southeast Florida, Inc. as an equal employment opportunity agency.
6. State and federal legislation imposes certain limitations on the employment of persons under the age of 18. Therefore, applicants shall be required to furnish proof of age after an offer of employment has been made. Offers of paid employment shall be automatically revoked when applicants under 18 are not able to provide a work permit.

Attachment F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101602	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 01/25/2011

NAME OF PROVIDER OR SUPPLIER: HOSPICECARE OF SOUTHEAST FLORIDA, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE: 308 SE 18TH STREET, FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS Hospicecare of Southeast Florida, Inc. was not in compliance with 42 CFR Part 418, Subpart A-H, Requirements for Hospice at the time of the Complaint Inspection. CCR#2011000729, survey visit conducted on 01/25/2011.	L 000	L528 (418.60) Infection Control: Expected Completion Date: February 24th 2011. To ensure that an effective infection control program is maintained and documented to protect patients, families, visitors, and staff by preventing and controlling infections and communicable diseases.	
L 578	418.60 INFECTION CONTROL The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation interview and record review, the Hospice failed to provide an effective infection control process to prevent the possible transmission of infectious agents as evidenced by the Hospice's failure to follow their own procedures for the washing of patient's personal belongings and the cleaning of the Residential Unit's floors. The findings include: 1. Review of the clinical records for Patient #2 reveals that the patient was admitted to the Hospice Unit on 02/17/10 with diagnoses to include Cerebral Vascular Accident and requires a tube feeding. Review of the clinical records for Patient #3 reveals that the patient was admitted to the Hospice Unit on 12/23/09 with diagnoses to include Cerebral Vascular Accident. Observation of Patient #3, on 01/25/11 at 9:20 AM reveals that the patient has a tracheostomy and requires suctioning. Observation, on 01/25/11 at 9:20 AM reveals the LPN (Licensed Practical Nurse) suctioning Patient #3 via the tracheostomy for	L 578	HCSEF's infection control policies regarding laundry and housekeeping services will be reviewed and updated following the CDC guidelines. HCSEF Clinical Manager/designee for the Residence will be responsible for oversight of the shopping list(s) and/or purchase orders to include chlorine bleach, non-chlorine bleach, laundry detergent, and an approved floor cleaning agent per HCSEF policy (ammonia, Lysol, or chlorine bleach). HCSEF's Education department will provide in-service education to all Residence staff and Float Pool staff to review infection control policies, specifically laundry and housekeeping policies at the Residence. The policies and procedures will be reviewed in their entirety using lecture and visual media to ensure all attendees clearly understand the policies and procedures in addition to the newly added laundry, housekeeping, and menu schedules. To guarantee that all required staff members receive in-service education on these topics, a roster of all actively employed residence	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melinda [signature] TITLE: Director of Performance Improvement DATE: 2-8-2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
FEB 09 2011
BY:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	101502		C 01/25/2011

NAME OF PROVIDER OR SUPPLIER
HOSPICECARE OF SOUTHEAST FLORIDA, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE
309 SE 18TH STREET
FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS Hospicecare of Southeast Florida, Inc. was not in compliance with 42 CFR Part 418, Subpart A-H, Requirements for Hospice at the time of the Complaint Inspection, CCR#2011000729, survey visit conducted on 01/25/2011.	L 000		
L 578	418.60 INFECTION CONTROL The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation interview and record review, the Hospice failed to provide an effective infection control process to prevent the possible transmission of infectious agents as evidenced by the Hospice's failure to follow their own procedures for the washing of patient's personal belongings and the cleaning of the Residential Unit's floors. The findings include: 1. Review of the clinical records for Patient #2 reveals that the patient was admitted to the Hospice Unit on 02/17/10 with diagnoses to include Cerebral Vascular Accident and requires a tube feeding. Review of the clinical records for Patient #3 reveals that the patient was admitted to the Hospice Unit on 12/23/09 with diagnoses to include Cerebral Vascular Accident. Observation of Patient #3, on 01/25/11 at 9:20 AM reveals that the patient has a treacheostomy and requires suctioning. Observation, on 01/25/11 at 9:20 AM reveals the LPN (Licensed Practical Nurse) suctioning Patient #3 via the treacheostomy for	L 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101502	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER: HOSPICECARE OF SOUTHEAST FLORIDA, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE: 305 SR 18TH STREET, FORT LAUDERDALE, FL 33316	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 578	Continued From page 1 secretions. Observation, on 01/25/11 at 10:30 AM, on the residential unit revealed a washer and dryer with a bottle of bleach and a bottle of "Gain Original Fresh" laundry detergent on the top of the dryer. Further observation, on 01/25/11 at 10:30 AM, reveals a bath towel, washcloth and two pastel patterned cotton dusters in the washing machine. Interview, with the CNA (Certified Nurse Assistant), on 01/25/11 at 10:30 AM, reveals that the cotton dusters belong to Patient #2 and #3 and that general laundry is picked up, done and returned to the Hospice by a laundry company twice weekly. When asked how this laundry, in the washing machine was done, during an interview, on 01/25/11 at 10:30 AM, the CNA stated, I use Gain and on rare occasions bleach, not always, only if really necessary, for socks." Review of the Hospice policy, "Laundry Service" reveals documentation, in part, regarding the washing of patient's personal belongings, "a laundry disinfectant product should be used: colored clothing use non-chlorine bleach." Interview, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that the Hospice does not have non-chlorine bleach available, at this time, to add to the washing machine, for the patient's laundry. Interview with CNA #1, on 01/25/11 at 2:40 PM reveals that she washes the floors of the residential unit with, "Fabuloso and a little bleach, about 4 caps in a pail of water." Review of the Hospice's Residence General Housekeeping policy reveals, in part, that the chemicals which may be used to provide a clean safe environment are ammonia, Lysol or chlorine bleach. Review of the ingredients of Fabulosu, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that Fabuloso does not contain any of those ingredients which are	L 578	and float pool staff will be printed and used as the sign-in sheet. The staff member will be required to sign next to their name. The Chief Operating Officer/designee will monitor and review the sign-in sheets to ensure all required staff have been in-serviced. Infection control is included as part of the New Hire Orientation and Individual policies and procedures are reviewed with the employee by their immediate supervisor. To monitor progress and adherence to stated policy, a weekly Laundry, Housekeeping, and Menu schedule will be developed whereas housekeeping and laundry tasks will be assigned and staff will initial the log as tasks are completed. The Clinical Manager for the Residence will be responsible for inspection and oversight. The completed logs will be scanned kept electronically and available for review.	

MJ 2-8-2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	101502		C 01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOSPICECARE OF SOUTHEAST FLORIDA, INC.	309 SE 18TH STREET FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 578	Continued From page 1 secretions. Observation, on 01/25/11 at 10:30 AM, on the residential unit revealed a washer and dryer with a bottle of bleach and a bottle of "Gain Original Fresh" laundry detergent on the top of the dryer. Further observation, on 01/25/11 at 10:30 AM, reveals a bath towel, washcloth and two pastel patterned cotton dusters in the washing machine. Interview, with the CNA (Certified Nurse Assistant), on 01/25/11 at 10:30 AM, reveals that the cotton dusters belong to Patient #2 and #3 and that general laundry is picked up, done and returned to the Hospice by a laundry company twice weekly. When asked how this laundry, in the washing machine was done, during an interview, on 01/25/11 at 10:30 AM, the CNA stated, I use Gain and on rare occasions bleach, not always, only if really necessary, for socks." Review of the Hospice policy, "Laundry Service" reveals documentation, in part, regarding the washing of patient ' s personal belongings, "a laundry disinfectant product should be used: colored clothing use non-chlorine bleach." Interview, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that the Hospice does not have non-chlorine bleach available, at this time, to add to the washing machine, for the patient's laundry. Interview with CNA #1, on 01/25/11 at 2:40 PM reveals that she washes the floors of the residential unit with, "Fabuloso and a little bleach, about 4 caps in a pail of water." Review of the Hospice's Residence General Housekeeping policy reveals, in part, that the chemicals which may be used to provide a clean safe environment are ammonia, Lysol or chlorine bleach. Review of the ingredients of Fabuloso, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that Fabuloso does not contain any of those ingredients which are	L 578		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 209 SE 18TH STREET FORT LAUDERDALE, FL 33316	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 578	Continued From page 2 documented in the Hospice's policy.	L 578		

MD 2-8-2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	101502		C 01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOSPICECARE OF SOUTHEAST FLORIDA, INC.	309 SE 18TH STREET FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 578	Continued From page 2 documented in the Hospice's policy.	L 578		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 10TH STREET FORT LAUDERDALE, FL 33318		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	Initial Comments Hospicecare of Southeast Florida, Inc. had Licensure deficiencies identified at the time of the Complaint Inspection, CCR#2011000729, survey visit conducted on 01/25/2011. T 051 5RA-2.0236 Hospice Residential Units (1) Residential units, which are established by a licensed hospice provider, will not be required to be separately licensed. Residential units shall comply with local codes and ordinances governing zoning, fire, safety, and health standards. (2) Residential units shall be maintained in a manner which provides for maintaining personal hygiene of the patients and implementation of infection control procedures Equipment and furnishings in residential units will provide for the health care needs of the resident while providing a home like or non-institutional resident type of atmosphere. This STANDARD is not met as evidenced by: Based on observation interview and record review, the Hospice failed to provide an effective infection control process to prevent the possible transmission of infectious agents as evidenced by the Hospice's failure to follow their own procedures for the washing of patient's personal belongings and the cleaning of the Residential Unit's floors The findings include: 1. Review of the clinical records for Patient #2 reveals that the patient was admitted to the Hospice Unit on 02/17/10 with diagnoses to include Cerebral Vascular Accident and requires	T 000 T 051	T051 (5RA-2.0236) Infection Control: Expected Completion Date: February 24th 2011. To ensure that an effective infection control program is maintained and documented to protect patients, families, visitors, and staff by preventing and controlling infections and communicable diseases. HCSEF's Infection control policies regarding laundry and housekeeping services will be reviewed and updated following the CDC guidelines. HCSEF Clinical Manager/designee for the Residence will be responsible for oversight of the shopping list(s) and/or purchase orders to include chlorine bleach, non-chlorine bleach, laundry detergent, and an approved floor cleaning agent per HCSEF policy (ammonia, Lysol, or chlorine bleach). HCSEF's Education department will provide in-service education to all Residence staff and Float Pool staff to review infection control policies, specifically laundry and housekeeping policies at the Residence. The policies and procedures will be reviewed in their entirety using lecture and visual media to ensure all attendees clearly understand the policies and procedures in addition to the newly added laundry, housekeeping, and menu schedules. To guarantee that all required staff members receive in-service education on these topics,	

AHCA Form 3020-0001

Melinda Diaz Director of Performance Improvement 2-8-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STAFF FORM HD1411 If continuation sheet 1 of 5

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 18TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	Initial Comments Hospicecare of Southeast Florida, Inc. had Licensure deficiencies identified at the time of the Complaint Inspection, CCR#2011000729, survey visit conducted on 01/25/2011.	T 000		
T 051	58A-2.0236 Hospice Residential Units (1) Residential units, which are established by a licensed hospice provider, will not be required to be separately licensed. Residential units shall comply with local codes and ordinances governing zoning, fire, safety, and health standards. (2) Residential units shall be maintained in a manner which provides for maintaining personal hygiene of the patients and implementation of infection control procedures Equipment and furnishings in residential units will provide for the health care needs of the resident while providing a home-like or non-institutional resident type of atmosphere. This STANDARD is not met as evidenced by: Based on observation interview and record review, the Hospice failed to provide an effective infection control process to prevent the possible transmission of infectious agents as evidenced by the Hospice's failure to follow their own procedures for the washing of patient's personal belongings and the cleaning of the Residential Unit's floors. The findings include: 1. Review of the clinical records for Patient #2 reveals that the patient was admitted to the Hospice Unit on 02/17/10 with diagnoses to include Cerebral Vascular Accident and requires	T 051		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC2291D017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 18TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 051	Continued From page 1 a tube feeding. Review of the clinical records for Patient #3 reveals that the patient was admitted to the Hospice Unit on 12/23/09 with diagnoses to include Cerebral Vascular Accident. Observation of Patient #3, on 01/25/11 at 9:20 AM reveals that the patient has a treacheostomy and requires suctioning. Observation, on 01/25/11 at 9:20 AM reveals the LPN (Licensed Practical Nurse) suctioning Patient #3 via the treacheostomy for secretions. Observation, on 01/25/11 at 10:30 AM, on the residential unit revealed a washer and dryer with a bottle of bleach and a bottle of "Gain Original Fresh" laundry detergent on the top of the dryer. Further observation, on 01/25/11 at 10:30 AM, reveals a bath towel, washcloth and two pastel patterned cotton dusters in the washing machine. Interview, with the CNA (Certified Nurse Assistant), on 01/25/11 at 10:30 AM, reveals that the cotton dusters belong to Patient #2 and #3 and that general laundry is picked up, done and returned to the Hospice by a laundry company twice weekly. When asked how this laundry, in the washing machine was done, during an interview, on 01/25/11 at 10:30 AM, the CNA stated, I use Gain and on rare occasions bleach, not always, only if really necessary, for socks." Review of the Hospice policy, "Laundry Service" reveals documentation, in part regarding the washing of patient's personal belongings, "a laundry disinfectant product should be used: colored clothing use non-chlorine bleach." Interview, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that the Hospice does not have non chlorine bleach available, at this time, to add to the washing machine, for the patient's laundry. Interview with CNA #1, on 01/25/11 at 2:40 PM reveals that she washes the floors of the residential unit with, "Fabuloso and a little bleach, about 4 cups in a pail of water."	T 051	a roster of all actively employed residence and float pool staff will be printed and used as the sign-in sheet. The staff member will be required to sign next to their name. The Chief Operating Officer/designee will monitor and review the sign-in sheets to ensure all required staff have been in-serviced. Infection control is included as part of the New Hire Orientation and individual policies and procedures are reviewed with the employee by their immediate supervisor. To monitor progress and adherence to stated policy, a weekly Laundry, Housekeeping, and Menu schedule will be developed whereas housekeeping and laundry tasks will be assigned and staff will initial the log as tasks are completed. The Clinical Manager for the Residence will be responsible for inspection and oversight. The completed logs will be scanned, kept electronically, and available for review.	

MD 2-8-2011

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 18TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 051	Continued From page 1 a tube feeding. Review of the clinical records for Patient #3 reveals that the patient was admitted to the Hospice Unit on 12/23/09 with diagnoses to include Cerebral Vascular Accident. Observation of Patient #3, on 01/25/11 at 9:20 AM reveals that the patient has a treacheostomy and requires suctioning. Observation, on 01/25/11 at 9:20 AM reveals the LPN (Licensed Practical Nurse) suctioning Patient #3 via the treacheostomy for secretions. Observation, on 01/25/11 at 10:30 AM, on the residential unit revealed a washer and dryer with a bottle of bleach and a bottle of "Gain Original Fresh" laundry detergent on the top of the dryer. Further observation, on 01/25/11 at 10:30 AM, reveals a bath towel, washcloth and two pastel patterned cotton dusters in the washing machine. Interview, with the CNA (Certified Nurse Assistant), on 01/25/11 at 10:30 AM, reveals that the cotton dusters belong to Patient #2 and #3 and that general laundry is picked up, done and returned to the Hospice by a laundry company twice weekly. When asked how this laundry, in the washing machine was done, during an interview, on 01/25/11 at 10:30 AM, the CNA stated, I use Gain and on rare occasions bleach, not always, only if really necessary, for socks." Review of the Hospice policy, "Laundry Service" reveals documentation, in part, regarding the washing of patient ' s personal belongings, "a laundry disinfectant product should be used: colored clothing use non-chlorine bleach." Interview, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that the Hospice does not have non-chlorine bleach available, at this time, to add to the washing machine, for the patient's laundry. Interview with CNA #1, on 01/25/11 at 2:40 PM reveals that she washes the floors of the residential unit with, "Fabuloso and a little bleach, about 4 caps in a pail of water."	T 051		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 16TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 051	Continued From page 2 Review of the Hospice's Residence General Housekeeping policy reveals, in part, that the chemicals which may be used to provide a clean safe environment are ammonia, Lysol or chlorine bleach. Review of the ingredients of Fabuloso, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that Fabuloso does not contain any of those ingredients which are documented in the Hospice's policy	T 051	T125 (58A-2.019) Dietary Services and Nutritional Counseling: Expected Completion Date: February 24th 2011. To ensure that dietary services and counseling are available to all patients and families on an as needed basis. HCSEF policies on Dietary services and Nutritional counseling will be reviewed and updated. HCSEF will retain the services of a registered dietician to provide dietary services and nutritional counseling to all HCSEF patients and families on an as needed basis. The provision of these services and counseling will be documented in the patients medical record. HCSEF's Education department will provide in-service education to all clinical staff to review the role of the registered dietician as part of the hospice interdisciplinary team. The regulations and policies will be reviewed in their entirety using lecture and printed materials to ensure all attendees clearly understand the regulations and policies as they relate to the provision of dietary services and nutritional counseling for all HCSEF patients and their families. To guarantee that all required staff members receive in-service education on these topics, a roster of all actively employed clinical staff will be printed and used as the sign-in sheet. The staff member will sign next to their name. The Chief Operating Officer/designee will monitor and review the sign-in sheets to	
T 125	58A-2.019 Dietary Services and Nutritional Counseling The administrator shall ensure that dietary services and nutritional counseling are available to all patient and family units in all components of hospice care on and as-needed basis. (1) The administrator shall ensure the development, documentation and implementation of written policies and procedures for dietary services including nutritional counseling services. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Hospice Administrator failed to make available the services of a Licensed Dietician to assure that dietary counseling would be available. The findings are: 1. Review of the Hospice policy, "Hospice Residence Meal Service" reveals documentation, in part, " Diet manual/menus will be provided and or approved by the Registered Dietician. Will be reviewed at least annually." Further review of the "Menu Cycle Spreadsheet, prepared by the dietician reveals that it consists of a two week cycle and is dated, "11/09." Observation, in the	T 125		

MD 2-8-2011

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 18TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 051	Continued From page 2 Review of the Hospice's Residence General Housekeeping policy reveals, in part, that the chemicals which may be used to provide a clean safe environment are ammonia, Lysol or chlorine bleach. Review of the ingredients of Fabuloso, with the Director of Performance Improvement and Education, on 01/25/11 at 12:15 PM reveals that Fabuloso does not contain any of those ingredients which are documented in the Hospice's policy.	T 051		
T 125	58A-2.019 Dietary Services and Nutrutional Counseling The administrator shall ensure that dietary services and nutritional counseling are available to all patient and family units in all components of hospice care on and as-needed basis. (1) The administrator shall ensure the development, documentation and implementation of written policies and procedures for dietary services including nutritional counseling services. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Hospice Administrator failed to make available the services of a Licensed Dietician to assure that dietary counseling would be available. The findings are: 1. Review of the Hospice policy, "Hospice Residence Meal Service " reveals documentation, in part, " Diet manual/menus will be provided and or approved by the Registered Dietician. Will be reviewed at least annually." Further review of the "Menu Cycle Spreadsheet, prepared by the dietician reveals that it consists of a two week cycle and is dated, "11/09." Observation, in the	T 125		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER: HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 309 SE 10TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 125	Continued From page 3 Hospice residential unit, on 01/25/11, at 8:43 AM reveals a brown manila envelope in the shelf, over the sink, in the kitchen. Review of the contents of the manila envelope, with CNA (Certified Nurse Assistant) #1 on 01/25/11 at 8:43 AM reveals that it contains three "shopping lists" marked, "week one, week two and week three." Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that someone from the finance department does the shopping and an additional list of patient requests is also kept. Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that the menu cycle being followed is for "week three." Interview with Director of Performance Improvement and Education, on 01/25/11 at 11:05 AM reveals that the dietician left a few months ago. Further review revealed documentation the the dietician was last paid in July, 2010 and the registered nurses conduct the nutritional assessment. T 126 58A-2.019 Dietary Services and Nutritional Counseling (2) In hospice residential care and hospice inpatient care settings, the hospice shall provide consultation by a licensed dietitian on practical freedom-of-choice diets for hospice patients and shall ensure that patients' favorite foods are included in their diets whenever possible. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Hospice failed to make available the services of a Licensed Dietician. The findings are: 1. Review of the Hospice policy, "Hospice Residence Meal Service" reveals documentation.	T 125 T 126	ensure that all clinical staff have been in-serviced. New Hire orientation includes information on the members of the interdisciplinary team including but not limited to the Registered Dietician. To monitor progress and adherence to stated policy, the Clinical Managers will continue to include dietary services and nutritional counseling as part of the initial hospice plan of care, plan of care review every 14 days, as necessary, and encourage the use of the registered dietician as appropriate. T126 (58A-2.019) Dietary Services and Nutritional Counseling: Expected Completion Date: February 24th 2011. To ensure that dietary services and nutritional counseling are available to all patients and their families on an as needed basis. HCSEF's policies on Dietary Services and Nutritional Counseling will be reviewed and updated. HCSEF will retain the services of a registered dietician to provide dietary services, nutritional counseling, menu planning, and consultation on practical freedom-of-choice diets, and help ensure that patients favorite foods are included in their diets whenever possible to all HCSEF residence patients and families on an as needed basis.	

MD 2-8-2011

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 18TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 125	Continued From page 3 Hospice residential unit, on 01/25/11, at 8:43 AM reveals a brown manila envelope in the shelf, over the sink, in the kitchen. Review of the contents of the manila envelope, with CNA (Certified Nurse Assistant) #1 on 01/25/11 at 8:43 AM reveals that it contains three "shopping lists" marked, "week one, week two and week three." Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that someone from the finance department does the shopping and an additional list of patient requests is also kept. Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that the menu cycle being followed is for "week three." Interview with Director of Performance Improvement and Education, on 01/25/11 at 11:05 AM reveals that the dietician left a few months ago. Further review revealed documentation the the dietician was last paid in July, 2010 and the registered nurses conduct the nutritional assessment.	T 125		
T 126	58A-2.019 Dietary Services and Nutritional Counseling (2) In hospice residential care and hospice inpatient care settings, the hospice shall provide consultation by a licensed dietitian on practical freedom-of-choice diets for hospice patients and shall ensure that patients' favorite foods are included in their diets whenever possible. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Hospice failed to make available the services of a Licensed Dietician. The findings are: 1. Review of the Hospice policy, "Hospice Residence Meal Service " reveals documentation,	T 126		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER: HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 309 SE 18TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 126	Continued From page 4 in part, "Diet manual/menus will be provided and or approved by the Registered Dietician. Will be reviewed at least annually." Observation, in the Hospice residential unit, on 01/25/11, at 8:43 AM reveals a brown manila envelope in the shelf, over the sink, in the kitchen. Review of the contents of the manila envelope, with CNA (Certified Nurse Assistant) #1 on 01/25/11 at 8:43 AM reveals that it contains three "shopping lists" marked, "week one, week two and week three." Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that someone from the finance department does the shopping and an additional list of patient requests is also kept. Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that the menu cycle being followed is for "week three." Further review of the "Menu Cycle Spreadsheet, prepared by the dietician reveals that it consists of a two week cycle and is dated, "11/09." Interview with Director of Performance Improvement and Education, on 01/26/11 at 11:05 AM reveals that the dietician left a few months ago. Further review revealed documentation the the dietician was last paid in July, 2010 and the registered nurses conduct the nutritional assessment.	T 126	HCSEF Clinical Manager/designee for the Residence will be responsible for ensuring a three week menu rotation with the associated shopping lists and preparation instructions are in use and reviewed annually and on an as needed basis by the registered dietician. HCSEF's Education department will provide in-service education to all Residence staff and Float Pool staff to review the available dietary services, nutritional counseling, menu planning, and consultations for practical freedom-of-choice diets and placement of a patients favorite foods into their diets. The policies and procedures will be reviewed in their entirety using lecture and visual media to ensure all attendees clearly understand the policies and procedures in addition to the newly added laundry, housekeeping, and menu schedules. To guarantee that all required staff members receive in-service education on these topics, a roster of all actively employed residence and float pool staff will be printed and used as the sign-in sheet. The staff member will be required to sign next to their name. The Chief Operating Officer/designee will monitor and review the sign-in sheets to ensure all required staff have been in-serviced. To monitor progress and adherence to stated policy, a weekly Laundry, Housekeeping, and Menu schedule will be developed whereas weekly review of the menu rotation and shopping lists will be assigned and staff will initial the log as tasks are completed. The Clinical Manager for the Residence will be responsible for inspection and oversight. The completed logs will be scanned, kept electronically and available for review.	

MD 2-8-2011

TOTAL P.11

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HC22910017	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER HOSPICECARE OF SOUTHEAST FLORIDA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 309 SE 18TH STREET FORT LAUDERDALE, FL 33316		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 126	Continued From page 4 in part, "Diet manual/menus will be provided and or approved by the Registered Dietician. Will be reviewed at least annually." Observation, in the Hospice residential unit, on 01/25/11, at 8:43 AM reveals a brown manila envelope in the shelf, over the sink, in the kitchen. Review of the contents of the manila envelope, with CNA (Certified Nurse Assistant) #1 on 01/25/11 at 8:43 AM reveals that it contains three "shopping lists" marked, "week one, week two and week three." Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that someone from the finance department does the shopping and an additional list of patient requests is also kept. Interview with CNA #1, on 01/25/11 at 8:43 AM reveals that the menu cycle being followed is for "week three." Further review of the "Menu Cycle Spreadsheet, prepared by the dietician reveals that it consists of a two week cycle and is dated, "11/09." Interview with Director of Performance Improvement and Education, on 01/25/11 at 11:05 AM reveals that the dietician left a few months ago. Further review revealed documentation the the dietician was last paid in July, 2010 and the registered nurses conduct the nutritional assessment.	T 126		

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
INTERIM SECRETARY

January 31, 2011

Administrator
Hospicecare Of Southeast Florida, Inc.
309 S.E. 18th Street
Fort Lauderdale, FL. 33316

Dear Administrator:

Re: CCR #2011000729

This letter reports the findings of a complaint inspection survey conducted on January 25, 2011 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiency and Plan of Correction, Form CMS 2567 and State (3020) Form indicating the deficiencies cited.

You will not receive a copy of this report in the mail; you will only receive this faxed report. A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office within 10 working days of receipt of this faxed report. Please enter your response to each deficiency on the right side of Form CMS 2567 and State Form 3020 opposite the deficiency and include the expected completion date in the last column. The POC must be signed and dated by the administrator or other authorized official. Failure to submit an acceptable POC within ten (10) working days may result in termination of your provider agreement. You will be notified by telephone and/or fax if your POC is found to be unacceptable. **All deficiencies shall be corrected no later than February 24, 2011.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- Dates when corrective action will be completed.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. If you have questions, please contact this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure:CMS Form 2567/ State Form 3020

7OL3

Attachment K

CAMP CORAL

Children and Teen Grief Support Camp, November 5-7, 2010

Camp Coral is an annual three day camp experience offered at no charge and facilitated by professional staff and trained volunteers of HospiceCare of Southeast Florida, Inc. The camp is for children from 6 - 13 years of age who have experienced the death of a loved one. Camp Coral combines a traditional, high energy, fun camp with grief support and education.

The camp provides a safe, caring environment, and offers fun recreational activities and supportive discussions to help campers build trust, self-esteem, and coping skills.

Being a grieving child can be a lonely experience. At camp, age appropriate groups provide an opportunity for campers to interact with peers also dealing with loss.

This year, Camp Coral will be held on November 5-7, 2010, in Pigeon Key, MM 47, Marathon, FL.

Campers will enjoy many camp activities including creative expression, remembrance activities, water activities, arts & crafts, sports, nature walks, games, and much more!

Campers will enjoy an enriched weekend of camp activities:

- Games
- Sports
- Nature Walks
- Water Activities
- Remembrance Activities
- Creative Expression
- Grief Support
- Arts & Crafts

For additional information on attending Camp Coral, or to become a Volunteer, please contact our Volunteer Department at 1 (800) HOSPICE, or visit our website at www.hospicecareflorida.org.

Volunteers Needed!

Camp Coral is made possible by the support of many dedicated volunteers. Volunteers are needed to serve as support to the children and as support to the staff to assist with many camp activities. Volunteeres must participate in training sessions to prepare for working with the children.

HospiceCare of Southeast Florida, Inc. is a non-profit organization providing hospice and palliative care, education, and bereavement support to terminally ill patients and their families in Miami-Dade, Monroe, and Broward Counties regardless of ability to pay.

We look forward to another wonderful Camp Coral Experience!

TiLLi KIDS

A Division of HospiceCare of Southeast Florida, Inc.

HospiceCare of Southeast Florida, Inc.

WWW.HOSPICECAREFLORIDA.ORG