

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2009 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009	
A	This return/report is for: ☐ a multiemployer plan; ☒ a single-employer plan; ☐ a multiple-employer plan; or ☐ a DFE (specify) ____
B	This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☐ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information—enter all requested information	
1a	Name of plan HOMECARE HOSPICE RETIREMENT PLAN	1b Three-digit plan number (PN) ▶ 001
		1c Effective date of plan 01/01/2004
2a	Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) HOMECARE HOSPICE, INC. 16482 HIGHWAY 21 WALNUT GROVE, MS 39189-6180	2b Employer Identification Number (EIN) 74-3069399
		2c Sponsor's telephone number 601-625-7840
		2d Business code (see instructions) 621610

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	07/08/2010	JAMES JONES, III
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") HOMECARE HOSPICE, INC. 16482 HIGHWAY 21 WALNUT GROVE, MS 39189-6180	3b Administrator's EIN 74-3069399 3c Administrator's telephone number 601-625-7840
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	7
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6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).		
a Active participants.....	6a	6
b Retired or separated participants receiving benefits.....	6b	
c Other retired or separated participants entitled to future benefits.....	6c	
d Subtotal. Add lines 6a , 6b , and 6c	6d	6
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	
f Total. Add lines 6d and 6e	6f	6
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	6
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 2E 2F 2G 2J 2K 3D

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1) ☐ **R** (Retirement Plan Information)
 (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
 (3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- (1) ☐ **H** (Financial Information)
 (2) ☒ **I** (Financial Information – Small Plan)
 (3) ☒ 1 **A** (Insurance Information)
 (4) ☐ **C** (Service Provider Information)
 (5) ☒ **D** (DFE/Participating Plan Information)
 (6) ☐ **G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2009 This Form is Open to Public Inspection
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For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009		
A Name of plan HOMECARE HOSPICE RETIREMENT PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500. HOMECARE HOSPICE, INC.		
D Employer Identification Number (EIN) 74-3069399		

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier
AXA EQUITABLE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5570651	62944	674945	6	01/01/2009	12/31/2009

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
279	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ROBERT L WHITE SUITE 8400 SKURLOCK RD CHATTANOOGA, TN 37411

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
112			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
CHARLES FORD 1200 PREMIER DR STE 135 CHATTANOOGA, TN 37421

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
90			3

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

JAMES IZETT

3348 PEACHTREE ROAD, NE SUITE 800
ATLANTA, GA 30326

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
53			3

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

EVELYN OSTHEIMER

3348 PEACHTREE ROAD, NE SUITE 800
ATLANTA, GA 30326

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
24			3

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	4866
5 Current value of plan's interest under this contract in separate accounts at year end	5	90057

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☒ other ▶ **GUARANTEED INTEREST CONTRACT**

b Balance at the end of the previous year	7b	4334
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c Additions: (1) Contributions deposited during the year	7c(1)	444	
	7c(2)		
	7c(3)	369	
	7c(4)	33653	
	7c(5)		

(6) Total additions	7c(6)	34466
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d Total of balance and additions (add b and c(6))	7d	38800
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2) Administration charge made by carrier	7e(2)	29	
(3) Transferred to separate account	7e(3)	33904	
(4) Other (specify below)	7e(4)	0	

▶ **OTHER**

(5) Total deductions	7e(5)	33933
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f Balance at the end of the current year (subtract e(5) from d)	7f	4867
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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
 b ☐ Dental
 c ☐ Vision
 d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
 f ☐ Long-term disability
 g ☐ Supplemental unemployment
 h ☐ Prescription drug
i ☐ Stop loss (large deductible)
 j ☐ HMO contract
 k ☐ PPO contract
 l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.	10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

a Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
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103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
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103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
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plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN

SCHEDULE I (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information—Small Plan This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2009 This Form is Open to Public Inspection
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009		
A Name of plan HOMECARE HOSPICE RETIREMENT PLAN		B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 HOMECARE HOSPICE, INC.		D Employer Identification Number (EIN) 74-3069399

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

1 Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
a Total plan assets	1a	103920	94924
b Total plan liabilities	1b		
c Net plan assets (subtract line 1b from line 1a)	1c	103920	94924
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable:			
(1) Employers	2a(1)	3186	
(2) Participants	2a(2)	3186	
(3) Others (including rollovers)	2a(3)		
b Noncash contributions	2b		
c Other income	2c	19656	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		26028
e Benefits paid (including direct rollovers)	2e	34899	
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Administrative service providers (salaries, fees, and commissions)	2h	125	
i Other expenses	2i		
j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		35024
k Net income (loss) (subtract line 2j from line 2d)	2k		-8996
l Transfers to (from) the plan (see instructions)	2l		

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

		Yes	No	Amount
a Partnership/joint venture interests	3a		X	
b Employer real property	3b		X	
c Real estate (other than employer real property)	3c		X	
d Employer securities	3d		X	
e Participant loans	3e		X	

	Yes	No	Amount
3f Loans (other than to participants)		X	
g Tangible personal property		X	

Part II	Compliance Questions
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4 During the plan year:	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)		X	
e Was the plan covered by a fidelity bond?	X		25000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	X		
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year..... ☐ Yes ☒ No Amount:

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)