Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2009** **This Form is Open to Public Inspection**

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 multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [X] 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:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
HOSPICE HOME CARE, INC 401K PROFIT SHARING PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 11/01/1994

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
HOSPICE HOME CARE, INC

2200 SOUTH BOWMAN ROAD
LITTLE ROCK, AR 72211

2200 SOUTH BOWMAN ROAD
LITTLE ROCK, AR 72211

2b Employer Identification Number (EIN) 71-0760807

2c Sponsor's telephone number 501-558-4132

2d Business code (see instructions) 621498

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.	10/14/2010	ERICA BULLOCH
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2010	ERICA BULLOCH
	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

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

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") HOSPICE HOME CARE, INC 2200 SOUTH BOWMAN ROAD LITTLE ROCK, AR 72211	**3b** Administrator's EIN 71-0760807 **3c** Administrator's telephone number 501-558-4132

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:		**4b** EIN
a Sponsor's name		**4c** PN

5 Total number of participants at the beginning of the plan year	**5**	138
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**	57
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	48
d Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	105
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f Total. Add lines **6d** and **6e**	**6f**	105
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	105
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	17
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

2E 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)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	**(1)** [X] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	**(2)** [ ] Code section 412(e)(3) insurance contracts
(3) [X] Trust	**(3)** [ ] Trust
(4) [ ] General assets of the sponsor	**(4)** [ ] General assets of the sponsor

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	**b General Schedules**
(1) [ ] **R** (Retirement Plan Information)	**(1)** [X] **H** (Financial Information)
(2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	**(2)** [ ] **I** (Financial Information – Small Plan)
	(3) [X] 1 **A** (Insurance Information)
	(4) [X] **C** (Service Provider Information)
(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	**(5)** [X] **D** (DFE/Participating Plan Information)
	(6) [ ] **G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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
HOSPICE HOME CARE, INC 401K PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500.
HOSPICE HOME CARE, INC

D Employer Identification Number (EIN)
71-0760807

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
MUTUAL OF AMERICA LIFE INSURANCE COMPANY

(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
13-1614399	88668	016588H	105	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
0	71

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
LADOVERICK HUGGINS
25 CENTURY BLVD, STE 411
NASHVILLE, TN 37214-3601

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
IVAN B. GREGORY
25 CENTURY BLVD, STE 411
NASHVILLE, TN 37214-3601

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

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

LINDA S. MURPHY
25 CENTURY BLVD, STE 411
NASHVILLE, TN 37214-3601

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

(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	435889
5	Current value of plan's interest under this contract in separate accounts at year end	5	585381

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.	6d	

Specify nature of costs ▶

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 ▶

b	Balance at the end of the previous year			7b	432669
c	Additions: (1) Contributions deposited during the year	7c(1)	21304		
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	12856		
	(4) Transferred from separate account	7c(4)	55108		
	(5) Other (specify below) ▶	7c(5)			
	(6) Total additions			7c(6)	89268
d	Total of balance and additions (add **b** and **c(6)**).			7d	521937
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	82136		
	(2) Administration charge made by carrier	7e(2)	1703		
	(3) Transferred to separate account	7e(3)	2209		
	(4) Other (specify below) ▶	7e(4)	0		
	(5) Total deductions			7e(5)	86048
f	Balance at the end of the current year (subtract **e(5)** from **d**)			7f	435889

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. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).	2009
Department of Labor Employee Benefits Security Administration	▶ **File as an attachment to Form 5500.**	**This Form is Open to Public Inspection.**
Pension Benefit Guaranty Corporation		

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
HOSPICE HOME CARE, INC 401K PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
HOSPICE HOME CARE, INC

D Employer Identification Number (EIN)
71-0760807

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . [X] Yes [ ] No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

FIDELITY MANAGEMENT & RESEARCH CO
82 DEVONSHIRE ST
BOSTON, MA 02109

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

THE VANGUARD GROUP
P.O. BOX 2600
VALLEY FORGE, PA 18482

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

DEUTSCH ASSET MANAGEMENT
222 SOUTH RIVERSIDE PLAZA
CHICAGO, IL 60606

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

OPPENHEIMER FUNDS, INC.
P.O. BOX 5270
DENVER, CO 80217

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

AMERICAN CENTURY INVESTMENT MGMT

P.O. BOX 419786
KANSAS CITY, MO 64141

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

CALVERT ASSET MANAGEMENT CO, INC.

4550 MONTGOMERY AVE, STE 1000N
BETHESDA, MD 20814

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

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

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

(a) Enter name and EIN or address (see instructions)

MUTUAL OF AMERICA LIFE INSURANCE CO
320 PARK AVENUE
NEW YORK, NY 10022

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
26		6049	Yes [X] No [ ]	Yes [X] No [ ]		Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN;
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN;
c Position:	
d Address:	**e** Telephone:

Explanation:

SCHEDULE D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.**	**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
HOSPICE HOME CARE, INC 401K PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
HOSPICE HOME CARE, INC

D Employer Identification Number (EIN)
71-0760807

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT NUMBER SA1

b Name of sponsor of entity listed in (a): MUTUAL OF AMERICA

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)
13-1614399-000	P	585381

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 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 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 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)

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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)

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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 plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

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a Plan name

b Name of plan sponsor

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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 plan sponsor

c EIN-PN

a Plan name

b Name of plan sponsor

c EIN-PN

SCHEDULE H (Form 5500)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**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
HOSPICE HOME CARE, INC 401K PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
HOSPICE HOME CARE, INC

D Employer Identification Number (EIN)
71-0760807

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		2703
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	19601	6784
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	59446	9808
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)	257433	310182
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	219577	275199
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	432670	435889
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	988727	1040565
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k		
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	988727	1040565

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. 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. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)		
(B) Participants	2a(1)(B)	78767	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		78767
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	12836	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	707	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		13543
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		

		(a) Amount	(b) Total
2b **(5)** Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		
(6) Net investment gain (loss) from common/collective trusts	2b(6)		59239
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		70897
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		222446

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	164679	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		164679
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)	5929	
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		5929
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		170608

Net Income and Reconciliation

k Net income (loss). Subtract line **2j** from line **2d**	2k		51838
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☐ Unqualified **(2)** ☐ Qualified **(3)** ☒ Disclaimer **(4)** ☐ Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? ☒ Yes ☐ No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: L. COTTON THOMAS & COMPANY **(2)** EIN: 71-0552273

d The opinion of an independent qualified public accountant is **not attached** because:

(1) ☐ This form is filed for a CCT, PSA, or MTIA. **(2)** ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.

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.)	4a	X		1003
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		130000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		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?	4g		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?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		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.	4n		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)

L. COTTON THOMAS & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS
620 WEST THIRD, SUITE 400
LITTLE ROCK, AR 72201-2224

MEMBERS AMERICAN INSTITUTE OF
CERTIFIED PUBLIC ACCOUNTANTS

Independent Auditors' Report

To The Board of Directors
Hospice Home Care, Inc. 401(k) Profit Sharing Plan
Little Rock, Arkansas

We were engaged to audit the accompanying statement of net assets available for benefits of Hospice Home Care, Inc. 401(k) Profit Sharing Plan as of December 31, 2009 and the related statement of changes in net assets available for benefits and for the year ended December 31, 2009, and the supplemental schedules as of and for the year ended December 31, 2009 as listed in the accompanying index. These financial statements and supplemental schedules are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified to by Mutual of America Life Insurance Company, the trustee of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the Plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The Plan administrator has obtained a certification from the trustee as of and for the years ended December 31, 2009 and 2008, that the information provided to the Plan administrator by the trustee is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and schedules taken as a whole. The form and content of the information included in the financial statements and schedules, other than that derived from the information certified to by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

L. Cotton Thomas and Company

October 14, 2010

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
SCHEDULE OF ASSETS HELD AT END OF YEAR
DECEMBER 31, 2009

71-0760807
Plan Number 001

Form 5500, Schedule H, Line 4i -
Schedule of Assets Held At End of Year

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
*	Interest Accumulation Account	Unallocated Annuity Contract		$ 435,889
*	Money Market Fund	3,404 shares, Interest-Bearing Cash		6,784
*	All America Fund MOA	1,148.48 shares, Common/Collective Trust		24,376
*	Bond Fund MOA	7,656.57 shares, Common/Collective Trust		26,832
*	Composite Fund MOA	13,998.13 shares, Common/Collective Trust		48,704
*	Mid-Term Bond Fund MOA	7,016.72shares, Common/Collective Trust		14,464
*	Mid-Cap Equity Index Fund MOA	23,431.51 shares, Common/Collective Trust		42,362
*	Equity Index Fund MOA	16,796.84 shares, Common/Collective Trust		46,788
*	Conservative Allocation Fund MOA	3,262.98 shares, Common/Collective Trust		4,109
*	Moderate Allocation Fund MOA	18,141.24 shares, Common/Collective Trust		24,351
*	Aggressive Allocation Fund MOA	20,874.49 shares, Common/Collective Trust		29,029

See independent auditors' report.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
SCHEDULE OF ASSETS HELD AT END OF YEAR
DECEMBER 31, 2009

71-0760807
Plan Number 001

Form 5500, Schedule H, Line 4i -
Schedule of Assets Held At End of Year

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
*	Mid Cap Value Fund MOA	1,690.56 shares, Common/Collective Trust		1,712
*	Small Cap Growth Fund MOA	13,859.20 shares, Common/Collective Trust		14,182
*	Small Cap Value Fund MOA	14,658.59 shares, Common/Collective Trust		15,986
*	International Fund MOA	4,355.10 shares, Common/Collective Trust		3,112
*	2020 Retirement Fund MOA	8,407.34 shares, Common/Collective Trust		7,327
*	2025 Retirement Fund MOA	6,748.73 shares, Common/Collective Trust		5,740
*	2040 Retirement Fund MOA	1,363,95 shares, Common/Collective Trust		1,108
	DWS Bond	228.97 shares, Registered Investment Company		3,943
	DWS Capital Growth	1,445.42 shares, Registered Investment Company		52,621
	DWS International	3,550.38 shares, Registered Investment Company		65,974
	American Century VP Cap Apprec	627.23 shares, Registered Investment Company		12,990
	Fidelity VIP Asset Manager	406.43 shares, Registered Investment Company		12,287

See independent auditors' report.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
SCHEDULE OF ASSETS HELD AT END OF YEAR (CONTINUED)
DECEMBER 31, 2009

71-0760807
Plan Number 001

Form 5500, Schedule H, Line 4i -
Schedule of Assets Held At End of Year

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
	Fidelity VIP Equity-Income	1,049.37 shares, Registered Investment Company		37,402
	Fidelity VIP Contrafund	1,437.42 shares, Registered Investment Company		56,230
	Fidelity VIP Mid Cap	579.87 shares, Registered Investment Company		21,709
	Vanguard VIF Diversified Value	66.63 shares, Registered Investment Company		921
	Vanguard VIF International	509.04 shares, Registered Investment Company		9,937
	Oppenheimer Main Street VA	59.72 share Registered Investment Company		1,185
	Participant Loans	4.00% - 7.50%		9,808
				$ 1,037,862

NOTE: Column (a) * Denotes exempt parties-in-interest transactions.

See independent auditors' report.

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Independent Auditors' Report

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SUPPLEMENTAL SCHEDULES

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HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
STATEMENT OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2009 AND 2008

	2009	2008
Assets		
Investments (at fair value)	$ 1,028,054	$ 929,281
Participants loans	9,808	59,446
	1,037,862	988,727
Receivables		
Participants' contributions	2,703	
Total Assets	1,040,565	988,727
Net Assets Available for Benefits	$ 1,040,565	$ 988,727

See independent auditors' report and accompanying notes to financial statements.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEAR ENDED DECEMBER 31, 2009

ADDITIONS	
Additions to net assets attributed to:	
Investment income:	
Net appreciation in fair value of investments	$ 142,574
Interest	1,105
Net Investment Income	143,679
Contributions	
Participants'	78,767
Total Contributions	78,767
Total Additions	222,446
DEDUCTIONS	
Deductions from net assets attributed to:	
Benefits paid to participants	164,679
Administrative expenses	5,929
Total Deductions	170,608
Net Increase	51,838
Net Assets Available for Benefits, Beginning of Year	988,727
Net Assets Available for Benefits, End of Year	$ 1,040,565

See independent auditors' report and accompanying notes to financial statements.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2009

NOTE 1: DESCRIPTION OF THE PLAN

The following description of the Plan provides only general information. Participants should refer to the *Summary Plan Description* for a more complete description of the Plan's provisions, which is available from the Plan administrator.

General

The Plan is a defined contribution plan covering all full-time employees of the Company who are age 21 or older. The Plan, which became effective November 1, 1994, is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

Participants may contribute a percentage of their annual wages up to the maximum amount allowed by the Internal Revenue Service. An employer match was provided until April 30, 2008. Contributions are subject to certain limitations. Participants direct the investment of all contributions into any of twenty-nine investment options offered by the Plan.

Participant Accounts

Each participant's account is credited with the participant contribution and allocations of the Company's contribution, if any, Plan earnings, and charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting

Participants are immediately vested in their voluntary contributions plus earnings thereon. Vesting in the Company's contribution portion of their accounts plus earnings thereon is based on years of continuous service. A participant is fully vested in the profit sharing plan after six years of continuous service. The nonvested balance is forfeited upon termination of service.

Forfeited Accounts

At December 31, 2009 and 2008, forfeited nonvested accounts totaled $12,893 and $7,418, respectively. These accounts will be used to reduce plan expenses.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS (CONTINUED)
DECEMBER 31, 2009

NOTE 1: DESCRIPTION OF THE PLAN (CONTINUED)

Participant Loans

Participants may borrow from their fund accounts a minimum of $1,000 up to a maximum equal to the lesser of $50,000 or 50% of their account balance. The loans are secured by the balance in the participant's account and bear interest at rates ranging from 4.00% to 7.50%, which are commensurate with local prevailing rates as determined quarterly by the Plan administrator. Principal and interest is paid ratably through monthly payroll deductions.

Payment of Benefits

On termination of service due to death, disability or retirement, a participant may elect to receive either a lump-sum amount equal to the value of the participant's vested interest in his or her account, or an annuity payable over terms ranging from 36 to 180 months. For termination of service due to other reasons, a participant may receive the value of the vested interest in his or her account as a lump-sum distribution.

Plan Termination

Although it has not expressed an intention to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan, subject to the provisions of ERISA. In the event of Plan termination, participants will become 100% vested in their accounts.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Valuation of Investments and Income Recognition

The Plan's investments are stated at fair value. Quoted market prices are used to value investments. Shares of registered investment companies and separate account funds are valued at the net asset value of shares held by the Plan at year end. Participant loans are valued at their outstanding balances, which approximate fair value.

Purchases and sales of securities are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Plan administrator to make estimates and assumptions that affect the reported amounts and disclosures. Actual results could differ from those estimates.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Plan Tax Status

The Plan is a prototype plan and the prototype's sponsor has been informed by the Internal Revenue Service that the Plan and related trust are designed in accordance with applicable Sections of the Internal Revenue Code.

Although the Plan's prototype has been amended since the determination letter, the Plan administrator believes the Plan is designed and is currently being operated in compliance with the applicable requirements of the Internal Revenue Code.

Payment of Benefits

Benefits are recorded when paid.

Operating Expenses

Most expenses of maintaining the Plan are paid by the Company.

Fair Value Measurements

The Plan determines the fair market values of its financial assets and liabilities, that are recognized or disclosed at fair value on a recurring basis, based on the fair value hierarchy established in ASC 820-10. The standard describes three levels of inputs that may be used to measure fair value.

Level 1 Quoted prices in active markets for identical assets. Level 1 assets include equity securities that are traded in an active exchange market, as well as certain U.S. Treasury securities that are highly liquid and are actively traded in over-the-counter markets.

Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments. This category generally includes U.S. government and agency mortgage-backed debt securities and corporate debt securities.

Level 3 Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include items where the determination of fair value requires significant management judgment or estimation.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS (CONTINUED)
DECEMBER 31, 2009

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Income Taxes

All income of the Plan is exempt from federal income tax as an organization described in section 501(c)(3) of the Internal Revenue Code. No part of the income or assets of the Plan shall be distributed to, or insure to the benefit of, any individual.

Basis of Accounting

Investment contracts held by a defined-contribution plan are required to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a defined contribution plan attributable to fully benefit-responsive investment contracts because value is the amount participants would receive if they were to initiate permitted transactions under the terms of the plan. As required by the generally accepted accounting principles, the Statement of Net Assets Available for Benefits presents the fair value of the investment contracts as well as the adjustment of the fully benefit-responsive investment contracts from fair value to contract value. The Statement of Changes in Net Assets Available for Benefits is prepared on a contract value basis.

NOTE 3: INVESTMENTS

The Plan's investments are held by Mutual of America Life Insurance Company. The following table presents the Plan's investments. Investments that represent 5% or more of total Plan assets are separately identified.

	Number of Shares December 31		Fair Market Value December 31	
	2009	2008	2009	2008
General Account Funds				
Interest Accumulation Account			$ 435,889	$ 432,670
			435,889	432,670
Registered Investment Companies				
DWS Capital Growth	1,445	1,381	52,621	39,990
DWS International	3,550	3,561	65,974	50,005
Fidelity VIP Contrafund	1,437	1,371	56,230	39,841
			174,825	129,836
Others			417,340	366,775
Total Investments			$ 1,028,054	$ 929,281

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS (CONTINUED)
DECEMBER 31, 2009

NOTE 3: INVESTMENTS (CONTINUED)

During 2009, the Plan's investments (including gains and losses on investments bought and sold, as well as held during the year) appreciated in value by $142,574 as follows:

Money Market Funds	$ 12,438
Separate Account Funds	59,239
Registered Investment Companies	70,897
Net appreciation (depreciation)	$ 142,574

NOTE 4: INFORMATION CERTIFIED TO BY TRUSTEE OF PLAN

	2009	2008
Short-Term Money Market Funds	$ 6,784	$ 19,601
Unallocated Annuity Contract	435,889	432,670
Separate Account Funds	310,182	257,433
Registered Investment Companies	275,199	219,577
	$ 1,028,054	$ 929,281

NOTE 5: RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near-term and that such changes could materially affect participants' account balances and the amounts reported in the statement of net assets available for benefits.

NOTE 6: RELATED PARTY TRANSACTIONS

The Plan incurs expenses related to general administration and record keeping. The Plan sponsor pays most of these expenses and certain accounting and auditing fees relating to the Plan.

The Plan holds investments in an unallocated annuity contract managed by Mutual of America Life Insurance Company, which is a trustee of the Plan. These investments qualify as exempt party-in-interest transactions.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS (CONTINUED)
DECEMBER 31, 2009

NOTE 7: FAIR VALUE DISCLOSURES

As discussed in Note 2, Hospice Home Care, Inc. 401(k) Profit Sharing Plan adopted the provisions FASB ASC 820-10. FASB ASC 820-10 defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. For additional information, refer to Note 2 "Summary of Significant Accounting Policies.

	Fair Value Measurements Using			
December 31, 2009	Level 1	Level 2	Level 3	Assets At Fair Value
Money Market Fund	$ 6,784			$ 6,784
Separate Account Fund	310,182			310,182
Registered Investment Companies	275,199			275,199
Interest accumulation account			$ 435,889	435,889
Participant Loans			9,808	9,808
Total Fair Value	$ 592,165	$ 0	$ 445,697	$ 1,037,862

December 31, 2008	Level 1	Level 2	Level 3	Assets At Fair Value
Money Market Fund	$19,601			$ 19,601
Separate Account Fund	257,433			257,433
Registered Investment Companies	219,577			219,577
Interest accumulation account			$ 432,670	432,670
Participant Loans			59,446	59,446
Total Fair Value	$ 496,611	$ -0-	$ 492,116	$ 988,727

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
NOTES TO FINANCIAL STATEMENTS (CONTINUED)
DECEMBER 31, 2009

NOTE 7: FAIR VALUE DISCLOSURES (CONTINUED)

The table below sets forth a summary of changes in the fair value of the Plan's level 3 assets for the years ended December 31, 2008 and 2009.

	Participant Loans	Interest Accumulation Account
Balance, December 31, 2007	$ 9,111	$ 447,862
Purchases, sales, issuances and settlement (net)	50,335	(15,192)
Balance, December 31, 2008	$ 59,446	$ 432,670
Purchases, sales, issuances and settlements (net)	(49,638)	3,219
Balance, December 31, 2009	$ 9,808	$ 435,889

NOTE 8: INVESTMENT CONTRACT WITH INSURANCE COMPANY

The *Interest Accumulation Account* is a benefit-responsive investment contract with Mutual of America Life Insurance Company (MOA). MOA maintains the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The contract is included in the financial statements at contract value as reported to the plan by MOA. Contract value represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value. The guaranteed investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan.

As described in Note 2, because the guaranteed investment contract is fully benefit-responsive, contract value is the relevant measurement attribute for that portion of the net assets available for benefits attributable to the guaranteed investment contract.

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The fair value of the investment contract at December 31, 2009 and 2008 was $435,889 and $432,670, respectively. The crediting interest rate was 3% for 2009. Interest rates are reviewed on a quarterly basis for resetting.

NOTE 9: SUBSEQUENT EVENTS

Hospice Home Care, Inc. 401(k) Profit Sharing Plan did not have any recognized or nonrecognized subsequent events occur after December 31, 2009, the balance sheet date. Subsequent events have been evaluated through October 14, 2010, the date the financial statements were available to be issued.

SUPPLEMENTAL SCHEDULES

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
SCHEDULE OF ASSETS HELD AT END OF YEAR
DECEMBER 31, 2009

71-0760807
Plan Number 001

Form 5500, Schedule H, Line 4i -
Schedule of Assets Held At End of Year

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
*	Interest Accumulation Account	Unallocated Annuity Contract		$ 435,889
*	Money Market Fund	3,404 shares, Interest-Bearing Cash		6,784
*	All America Fund MOA	1,148.48 shares, Common/Collective Trust		24,376
*	Bond Fund MOA	7,656.57 shares, Common/Collective Trust		26,832
*	Composite Fund MOA	13,998.13 shares, Common/Collective Trust		48,704
*	Mid-Term Bond Fund MOA	7,016.72shares, Common/Collective Trust		14,464
*	Mid-Cap Equity Index Fund MOA	23,431.51 shares, Common/Collective Trust		42,362
*	Equity Index Fund MOA	16,796.84 shares, Common/Collective Trust		46,788
*	Conservative Allocation Fund MOA	3,262.98 shares, Common/Collective Trust		4,109
*	Moderate Allocation Fund MOA	18,141.24 shares, Common/Collective Trust		24,351
*	Aggressive Allocation Fund MOA	20,874.49 shares, Common/Collective Trust		29,029

See independent auditors' report.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
SCHEDULE OF ASSETS HELD AT END OF YEAR
DECEMBER 31, 2009

71-0760807
Plan Number 001

Form 5500, Schedule H, Line 4i -
Schedule of Assets Held At End of Year

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
*	Mid Cap Value Fund MOA	1,690.56 shares, Common/Collective Trust		1,712
*	Small Cap Growth Fund MOA	13,859.20 shares, Common/Collective Trust		14,182
*	Small Cap Value Fund MOA	14,658.59 shares, Common/Collective Trust		15,986
*	International Fund MOA	4,355.10 shares, Common/Collective Trust		3,112
*	2020 Retirement Fund MOA	8,407.34 shares, Common/Collective Trust		7,327
*	2025 Retirement Fund MOA	6,748.73 shares, Common/Collective Trust		5,740
*	2040 Retirement Fund MOA	1,363,95 shares, Common/Collective Trust		1,108
	DWS Bond	228.97 shares, Registered Investment Company		3,943
	DWS Capital Growth	1,445.42 shares, Registered Investment Company		52,621
	DWS International	3,550.38 shares, Registered Investment Company		65,974
	American Century VP Cap Apprec	627.23 shares, Registered Investment Company		12,990
	Fidelity VIP Asset Manager	406.43 shares, Registered Investment Company		12,287

See independent auditors' report.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
SCHEDULE OF ASSETS HELD AT END OF YEAR (CONTINUED)
DECEMBER 31, 2009

71-0760807
Plan Number 001

Form 5500, Schedule H, Line 4i -
Schedule of Assets Held At End of Year

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
	Fidelity VIP Equity-Income	1,049.37 shares, Registered Investment Company		37,402
	Fidelity VIP Contrafund	1,437.42 shares, Registered Investment Company		56,230
	Fidelity VIP Mid Cap	579.87 shares, Registered Investment Company		21,709
	Vanguard VIF Diversified Value	66.63 shares, Registered Investment Company		921
	Vanguard VIF International	509.04 shares, Registered Investment Company		9,937
	Oppenheimer Main Street VA	59.72 share Registered Investment Company		1,185
	Participant Loans	4.00% - 7.50%		9,808
				$ 1,037,862

NOTE: Column (a) * Denotes exempt parties-in-interest transactions.

See independent auditors' report.

HOSPICE HOME CARE, INC. 401(k) PROFIT SHARING PLAN
SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS
DECEMBER 31, 2009

71-0760807
Plan Number 001

Form 5500, Schedule H, Line 4a -
Schedule of Delinquent Participant Contributions

Participant Contributions Transferred Late to Plan	Total that Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under VFCP and PTE 2002-51
Check here if Late Participant Loan Repayments are included: ☒	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
2007				
$ 115,570	$ 115,570			
2008				
24,946	24,946			
2009				
1,003	1,003			
$ 141,519	$ 141,519			$ -0-

See independent auditors' report.