

Return of Organization Exempt From Income Tax

2011

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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.

A For the 2011 calendar year, or tax year beginning 4/6/2011, and ending 12/31/2011

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

C Name of organization MIAMI RESCUE MISSION CLINIC INC
 Doing Business As _____
 Number and street (or P.O. box if mail is not delivered to street address) Room/suite
2015 NW 1ST AVENUE
 City or town, state or country, and ZIP + 4
MIAMI FL 33127

D Employer identification number 45-1481860

E Telephone number _____

F Name and address of principal officer:
PETER GUTIERREZ, MD, MMS, PA-C 2015 NW 1ST AVENUE, MIAMI

G Gross receipts \$ 18,872

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)

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

J Website: WWW.CARINGPLACECLINIC.ORG

K Form of organization: Corporation Trust Association Other ▶

L Year of formation: 2011 **M** State of legal domicile: FL

H(c) Group exemption number ▶ _____

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: <u>TO PROVIDE ACCESS TO COMPREHENSIVE PRIMARY HEALTHCARE TO THE COMMUNITY'S HOMELESS, MEDICALLY UNINSURED AND UNDERSERVED, AS WELL AS TO IMPLEMENT AND DELIVER COMMUNITY OUTREACH PROGRAMS THAT INCLUDE HEALTHCARE SCREENINGS, INFORMATION AND EDUCATION, INCLUDING GUIDANCE ON AND REFERRALS TO THE FULL</u>		
	2	Check this box <input type="checkbox"/> 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	5
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	5
	5	Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	2
	6	Total number of volunteers (estimate if necessary)	6	
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
7b	Net unrelated business taxable income from Form 990-T, line 34	7b	0	
Revenue	8	Contributions and grants (Part VIII, line 1h)	Prior Year 0	Current Year 18,872
	9	Program service revenue (Part VIII, line 2g)		0
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)		0
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		0
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	0	18,872
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)		0
	14	Benefits paid to or for members (Part IX, column (A), line 4)		0
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		1,218
	16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ <u>0</u>		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)		15,445	
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	0	16,663	
19	Revenue less expenses. Subtract line 18 from line 12	0	2,209	
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	Beginning of Current Year 0	End of Year 2,209
	21	Total liabilities (Part X, line 26)	0	0
	22	Net assets or fund balances. Subtract line 21 from line 20	0	2,209

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 Use Only

Print/Type preparer's name ELIAS TACHER Preparer's signature _____ Date 5/30/2012 Check if self-employed PTIN P00180132

Firm's name ▶ ELIAS TACHER, CPA, PA Firm's EIN ▶ 26-0021592

Firm's address ▶ 9250 SW 59 STREET, MIAMI, FL 33173-1660 Phone no. (786) 202-3049

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

For Paperwork Reduction Act Notice, see the separate instructions.

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III []

1 Briefly describe the organization's mission: SEE SCHEDULE O

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 [X] No

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured 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 \$ 13,699 including grants of \$ 0) (Revenue \$ 18,872) THE CLINIC IS PROUD TO SERVE THE LOCAL COMMUNITY WITH THE HIGHEST STANDARDS OF MEDICAL CARE IN AN ENVIRONMENT IN WHICH EACH PATIENT IS TREATED WITH DIGNITY AND RESPECT, AND WITHOUT REGARD TO RACE, AGE, GENDER, ETHNICITY, RELIGIOUS AFFILIATION OR FINANCIAL STATUS.

4b (Code:) (Expenses \$ 0 including grants of \$ 0) (Revenue \$ 0)

4c (Code:) (Expenses \$ 0 including grants of \$ 0) (Revenue \$ 0)

4d Other program services. (Describe in Schedule O.) (Expenses \$ 0 including grants of \$ 0) (Revenue \$ 0)

4e Total program service expenses 13,699

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

2011

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Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

Name of the organization

MIAMI RESCUE MISSION CLINIC INC

Employer identification number

45-1481860

Form 990 MIAMI RESCUE MISSION CLINIC INC IS COMMITTED TO PROVIDE ACCESS TO COMPREHENSIVE

PRIMARY HELATHCARE TO THE COMMUNITY'S HOMELESS, MEDICALLY UNINSURED AND UNDERSERVED, AS WELL

AS TO IMPLEMENT AND DELIVER COMMUNITY OUTREACH PROGRAMS THAT INCLUDE HEALTH SCREENINGS,

INFORMATION, EDUCATION, INCLUDING GUIDANCE ON AND REFERRALS TO THE FULL CONTINUUM OF PERSONAL

AND COMMUNITY DEVELOPMENT. TO THIS END, MIAMI RESCUE MISSION CLINIC INC WILL SERVE THE LOCAL

COMMUNITY WITH THE HIGHEST STANDARDS OF MEDICAL CARE IN AN ENVIRONMENT IN WHICH EACH PATIENT IS

TREATED WITH DIGNITY AND RESPECT.