

Form 5500 <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<div style="text-align: right;">OMB Nos. 1210-0110 1210-0089</div> <hr/> <div style="text-align: center; font-size: 1.5em; font-weight: bold;">2009</div> <hr/> <div style="text-align: center;">This Form is Open to Public Inspection</div>
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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 01/01/2009	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan; or ☒ a single-employer plan; ☐ 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 ALPINE HOME HEALTH INC. 401K & PROFIT SHARING PLAN 2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) ALPINE HOME HEALTH, INC. 6500 W FREEWAY STE 900 ONE RIDGMAR CENTER FORT WORTH, TX 76116	1b Three-digit plan number (PN) ▶ 001	1c Effective date of plan 01/01/2001		
	2b Employer Identification Number (EIN) 64-0921774	2c Sponsor's telephone number 817-551-0355	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.	04/01/2011	MIKE MILLER
	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

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

Form 5500 (2009)
v.092307.1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") ALPINE HOME HEALTH, INC. 6500 W FREEWAY STE 900 ONE RIDGMAR CENTER FORT WORTH, TX 76116	3b Administrator's EIN 64-0921774 3c Administrator's telephone number 817-551-0355
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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	128
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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	0
b Retired or separated participants receiving benefits.....	6b	0
c Other retired or separated participants entitled to future benefits.....	6c	0
d Subtotal. Add lines 6a , 6b , and 6c	6d	0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	0
f Total. Add lines 6d and 6e	6f	0
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	0
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	0

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 2R 2T 3B 3D 3H

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) ☐ **A** (Insurance Information)
 (4) ☒ **C** (Service Provider Information)
 (5) ☐ **D** (DFE/Participating Plan Information)
 (6) ☐ **G** (Financial Transaction Schedules)

<div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div>	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 01/01/2009

<div>A</div> <div>Name of plan</div> <div>ALPINE HOME HEALTH INC. 401K & PROFIT SHARING PLAN</div>	<div>B</div> <div>Three-digit plan number (PN)</div> <div>▶</div> <div>001</div>
<div>C</div> <div>Plan sponsor's name as shown on line 2a of Form 5500</div> <div>ALPINE HOME HEALTH, INC.</div>	<div>D</div> <div>Employer Identification Number (EIN)</div> <div>64-0921774</div>

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).....

☐ 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

(b)

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

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

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

(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 ☐

(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
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(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:	WILEY, WILEY AND ASSOCIATES	b EIN:	20-4916740
c Position:	ACCOUNTANT		
d Address:	201 N 2ND ST LEESBURG, FL 34748	e Telephone:	352-787-0852

Explanation: A NEW AUDITOR WAS SELECTED BASED ON EXPERTISE AND PROPOSED FEES

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 H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information 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.	<small>OMB No. 1210-0110</small> 2009 This Form is Open to Public Inspection
For calendar plan year 2009 or fiscal plan year beginning <u>01/01/2009</u> and ending <u>01/01/2009</u>		
A Name of plan <u>ALPINE HOME HEALTH INC. 401K & PROFIT SHARING PLAN</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>ALPINE HOME HEALTH, INC.</u>	D Employer Identification Number (EIN) <u>64-0921774</u>	

Part I	Asset and Liability Statement		(a) Beginning of Year	(b) End of Year
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	Total noninterest-bearing cash	1a		
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions	1b(1)		
	(2) Participant contributions	1b(2)		
	(3) Other	1b(3)		
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
	(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)	2500	
	(9) Value of interest in common/collective trusts	1c(9)		
	(10) Value of interest in pooled separate accounts	1c(10)		
	(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)	149771	
	(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
	(15) Other	1c(15)		

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(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	152271	

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 through 1j)	1k		

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	152271	
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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 Contributions:**

		(a) Amount	(b) Total
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
(B) Participants	2a(1)(B)	139	
(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)		139

b Earnings on investments:**(1) Interest:**

(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(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)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		

(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)	80	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		80

(3) Rents	2b(3)		
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(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)		
(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)		510
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		729

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	6557	
(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)		6557
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)		
(4) Other	2i(4)	100	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		100
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		6657

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-5928
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		146343

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: WHITLEY PENN LLP

(2) EIN: 75-2393478

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.).....		X	
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.).....		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.)		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.).....		X	
e Was this plan covered by a fidelity bond?.....		X	
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 have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....		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.).....		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?.....	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)
VOYAGER HOSPICECARE INC 401K EMP BEN PLAN	20-1173787	001

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under section 104 and 4065 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 01/01/2009

A Name of plan <u>ALPINE HOME HEALTH INC. 401K & PROFIT SHARING PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>ALPINE HOME HEALTH, INC.</u>	D Employer Identification Number (EIN) <u>64-0921774</u>

Part I	Distributions
---------------	----------------------

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>57-1198022</u>	
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.	
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....	3

Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)
----------------	--

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?.....	☐ Yes	☐ No	☐ N/A
If the plan is a defined benefit plan, go to line 8.			
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year	6a		
b Enter the amount contributed by the employer to the plan for this plan year	6b		
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c		
If you completed line 6c, skip lines 8 and 9.			
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?	☐ Yes	☐ No	☐ N/A
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?.....	☐ Yes	☐ No	☐ N/A

Part III	Amendments
-----------------	-------------------

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box.....	☐ Increase	☐ Decrease	☐ Both	☐ No
--	-----------------------------------	-----------------------------------	-------------------------------	-----------------------------

Part IV	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
----------------	---

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?.....	☐ Yes	☐ No
11 a Does the ESOP hold any preferred stock?	☐ Yes	☐ No
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)	☐ Yes	☐ No
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?	☐ Yes	☐ No

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

Schedule R (Form 5500) 2009
v.092308.1

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

- 14** Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	14a	
b The plan year immediately preceding the current plan year	14b	
c The second preceding plan year	14c	

- 15** Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	

- 16** Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	

- 17** If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

- 18** If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

- 19** If the total number of participants is 1,000 or more, complete items (a) through (c)

a Enter the percentage of plan assets held as:
 Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate item 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

**ALPINE HOME HEALTH INC. 401(K) &
PROFIT SHARING PLAN**

FINANCIAL STATEMENTS

**Period Ended January 1, 2009
and Year Ended December 31, 2008
with Report of Independent Auditors**

**ALPINE HOME HEALTH INC. 401(K) &
PROFIT SHARING PLAN**

FINANCIAL STATEMENTS

**Period Ended January 1, 2009
and Year Ended December 31, 2008**

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NOTE: All schedules required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted since they are either not applicable or the information required therein has been included in the financial statements or notes thereto.

REPORT OF INDEPENDENT AUDITORS

To the Trustees of the
Alpine Home Health Inc. 401(k) & Profit Sharing Plan

We were engaged to audit the financial statements of the Alpine Home Health Inc. 401(k) & Profit Sharing Plan as of January 1, 2009, and for the period then ended, as listed in the accompanying table of contents. These financial statements 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 investment information which was certified by State Street Bank & Trust Company, the trustee of the Plan, except for comparing such information with the related information included in the financial statements. 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 January 1, 2009, that the information provided to the Plan Administrator by the trustee is complete and accurate.

The financial statements of the Plan as of and for the year ended December 31, 2008 were audited by other auditors. As permitted by 29 CFR 2520.130-8 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 the other auditors not to perform, and they did not perform, any auditing procedures with respect to the information certified by State Street Bank & Trust Company, the trustee of the Plan. Their report, dated October 8, 2009, indicated that (a) because of the significance of the information that they did not audit, they were unable to, and did not, express an opinion on the financial statements and supplemental schedules taken as a whole and (b) the form and content of the information included in the financial statements and supplemental schedules other than that derived from the information certified by the trustee, were 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.

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 2009 financial statements taken as a whole. The form and content of the information included in the financial statements, other than that derived from the information certified 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.



Fort Worth, Texas
March 17, 2011

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	January 1, 2009	December 31, 2008
Assets		
Investments, at fair value:		
Shares of registered investment companies:		
Mutual funds	\$ -	\$ 149,771
Participant loans	-	2,500
Total investments	-	152,271
Receivables:		
Participant contributions	-	139
Total receivables	-	139
Net assets available for benefits	\$ -	\$ 152,410

See accompanying notes to financial statements.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

	Period Ended January 1, 2009	Year Ended December 31, 2008
Additions to (Reductions from) Net Assets		
Investment income (loss):		
Net realized and unrealized gains (losses) on investments	\$ 510	\$ (104,402)
Interest and dividends	80	7,088
Total investment income (loss)	<u>590</u>	<u>(97,314)</u>
Contributions:		
Participants	-	25,395
Total contributions	<u>-</u>	<u>25,395</u>
Total additions to (reductions from) net assets	590	(71,919)
Deductions from Net Assets		
Benefits paid to participants	6,557	150,553
Administrative expenses	100	861
Transfer to another plan	146,343	-
Total deductions from net assets	<u>153,000</u>	<u>151,414</u>
Net decrease in net assets available for benefits	(152,410)	(223,333)
Net assets available for benefits at beginning of year	<u>152,410</u>	<u>375,743</u>
Net assets available for benefits at end of year	<u><u>\$ -</u></u>	<u><u>\$ 152,410</u></u>

See accompanying notes to financial statements.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS

January 1, 2009 and December 31, 2008

A. Description of the Plan

General

The following is a brief description of the Alpine Home Health Inc. 401(k) & Profit Sharing Plan (the “Plan”), which provides only general information. Participants should refer to the Plan document for more complete information. Prior to January 1, 2009, the Plan was sponsored by Alpine Home Health, Inc. (“Alpine Home Health” and “Company”) and effective January 1, 2009, the Plan is sponsored by Voyager HospiceCare, Inc. (“Voyager HospiceCare”) (collectively the “Plan Sponsor”). The Voyager HospiceCare’s corporate office is located in Fort Worth, Texas.

Alpine Home Health was acquired by Voyager HospiceCare on January 1, 2009. As a result, all Plan participants became participants in the Voyager HospiceCare, Inc. 401(k) Employee Benefit Plan (the “Voyager Plan”) and no employee or employer contributions were made to the Plan during 2009. Effective January 1, 2009, the assets and liabilities of the Plan were merged in the Voyager Plan.

The Plan was a defined contribution plan available to employees of the Alpine Home Health who had attained age 21 and completed one year of service. The Plan was subject to the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”).

The purpose of the Plan was to encourage the Company’s employees to save and invest, systematically, a portion of their current compensation so that they and their families may have a source of additional income upon their retirement, or in the event of death.

Contributions

Prior to January 1, 2009, participants of the Plan could contribute up to 15% of their pre-tax compensation, as defined in the Plan document. Contributions were subjected to limitations on annual additions and other limitations imposed by the Internal Revenue Code (the “Code”) as defined by the Plan document. Participants who were age 50 or older by the end of the calendar year were allowed to make an additional “catch-up” contribution.

The Plan allowed for a discretionary matching contribution which was determined by the Company. During 2009 and 2008, there were no matching contributions made to the Plan.

The Company, at its discretion, also had the option to contribute additional amounts, which would be allocated to participant accounts in proportion to their eligible compensation for the plan year. The Company did not elect to make discretionary contributions in 2009 or 2008.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS (*continued*)

A. Description of the Plan – continued

Participant Accounts

Each participant's account was credited with the participant's contributions and allocations of: (a) the Company's contribution; (b) Plan earnings; and, (c) forfeitures of terminated participants' non-vested accounts and charged with an allocation of administrative expenses. Allocations were based on participant earnings or account balances, as defined. The benefit to which a participant was entitled was the benefit that can be provided from the participant's vested account.

Vesting

Participants were immediately vested in their voluntary contributions plus actual earnings thereon. Vesting in the Company's contributions, plus actual earnings thereon was as follows:

<u>Years of service</u>	<u>Vesting Percentage</u>
Less than 2 years	0%
2 years	20%
3 years	40%
4 years	60%
5 years	80%
6 years or more	100%

In the event of disability, early retirement or death, a participant would become fully vested.

Participant Loans

Participants could borrow from their accounts a minimum of \$500 up to a maximum equal to the lesser of \$50,000 or 50% of their account balance. Loans had to be fully repaid through payroll deductions within 5 years unless the loan was used to purchase a primary residence, in which case the loan must be repaid within a period of no more than 30 years.

Any outstanding loans had to be repaid before a new loan could be made. Prepayment of an outstanding loan could have been made at any time by certified check. The interest rate on a new loan would be the effective rate, defined as the prime rate as published in *The Wall Street Journal* on the 14th day of each month plus two percentage points, for the month the loan was made. The loans were secured by the balance in the participant's account.

Benefit Payments

Participants withdrawing during the year for reasons of termination of service, disability, retirement or death were entitled to their vested account balance. Benefits were distributed in the form of rollover or lump distributions. If withdrawing participants were not entitled to their entire account balance, the amounts not received were forfeited.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS (*continued*)

A. Description of the Plan – continued

Benefit Payments – *continued*

A participant could receive a hardship distribution from their salary deferral contributions if the distribution was: (1) on account of uninsured medical expenses incurred by the participant, their spouse or dependents; (2) to purchase (excluding mortgage payments) a principal residence of the participant; (3) for burial or funeral expenses for the participant's deceased parent, spouse, children or dependents; (4) for the payment of post-secondary tuition expenses; (5) for the repair of damage to participant's principal residence; or, (6) needed to prevent eviction of the participant from his or her principal residence or foreclosure upon the mortgage of the participant's principal residence. Such distributions reduce the benefits available upon retirement; could only be made from the participants elective deferrals and was limited to two per Plan year.

Forfeited Accounts

Upon termination of employment of a participant, the non-vested portion of the participant's Company contributions' account was forfeited. The Company reserved the right to use the forfeited amounts to pay Plan expenses or reduce future Company contributions. During 2009, the Company did not utilize any forfeiture balances, however during 2008 the Company utilized \$30,000 of forfeiture balances in lieu of making matching contributions. As of December 31, 2008, there was approximately \$31,000 of unallocated forfeitures. All unallocated forfeitures were transferred to the Voyager Plan effective January 1, 2009.

Investment Options

Upon enrollment in the Plan, a participant could direct their salary deferrals in 1% increments into any of the Plan's investment options.

Administrative Expenses

Employees of the Plan Sponsor perform certain administrative functions with no compensation from the Plan. In accordance with Plan provisions, the Plan Sponsor paid substantially all costs relating to asset charges and recordkeeping. All significant administrative expenses were paid by the Plan Sponsor and are not reflected in the accompanying financial statements.

B. Summary of Significant Accounting Policies

Basis of Accounting

The financial statements of the Plan are presented on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS (continued)

B. Summary of Significant Accounting Policies – continued

Use of Estimates

The preparation of the 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 certain reported amounts and disclosures. Accordingly, actual results may differ from these estimates.

Investment Valuation and Income

The investments of the Plan are stated at fair value as of the end of the Plan year and are subject to market or credit risks customarily associated with equity investments. Fair value measurements are determined in accordance with Financial Accounting Standards Board (“FASB”) Accounting Standards Codification (“ASC”) Topic No. 820, *Fair Value Measurements*, which defines fair value, establishes a framework for measuring fair value, and require certain disclosures about assets and liabilities measured at fair value. See Note D for information related to the Plan’s valuation methodologies under FASB ASC Topic No. 820.

Investment gains and losses are accounted for using the average cost basis of the securities sold. The net realized and unrealized gains and losses on investments include realized gains and losses on sales of investments during the year and unrealized increases or decreases in the market value of investments held at year end. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.

Contributions

Contributions from the Company and participants are accrued as they become obligations of the Company or in the period in which they are deducted, in accordance with salary deferral agreements.

Payment of Benefits

Benefits are recorded when paid.

Reclassification

Certain 2008 amounts have been reclassified to conform to the 2009 presentation.

Recently Issued Accounting Pronouncement

In June 2009, the FASB issued a standard which established the FASB Accounting Standards Codification (“Codification”) as the source of authoritative accounting principles recognized by the FASB to be applied by nongovernmental entities in the preparation of financial statements in conformity with accounting principles generally accepted in the United States of America. The Codification was effective for financial statements issued for annual periods ending after September 15, 2009, and was early adopted by the Plan during the period ended January 1, 2009. Adoption of this standard did not impact the Plan’s financial statements.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS (*continued*)

B. Summary of Significant Accounting Policies – continued

Recently Issued Accounting Pronouncement – *continued*

In October 2008, the FASB issued FASB ASC Topic No. 855, *Subsequent Events*, which requires management to evaluate subsequent events through the date the financial statements are issued, or are available to be issued, as defined. It also requires the Plan to disclose in the financial statements, the date through which subsequent events have been evaluated.

C. Investments

Investments that represent 5% or more of net assets available for benefits at December 31, 2008 are as follows:

GS ILA Prime Obligations	\$ 72,196
GS Asset Alloc. Equity Growth	32,101
GS Capital Growth Fund	15,203
GS Struct U.S. Equity Fund	14,455

During 2009 and 2008, the Plan's net realized and unrealized gains (losses) on investments were all related to investments in mutual funds.

D. Fair Value Measurements

FASB ASC Topic No. 820 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date and establishes a three-tier hierarchy that is used to identify assets and liabilities measured at fair value. The hierarchy focuses on the inputs used to measure fair value and requires that the lowest level input be used. The three levels defined in FASB ASC Topic No. 820 are as follows:

- Level 1 — observable inputs that are based upon quoted market prices for identical assets or liabilities within active markets.
- Level 2 — observable inputs other than Level 1 that are based upon quoted market prices for similar assets or liabilities, based upon quoted prices within inactive markets, or inputs other than quoted market prices that are observable through market data for substantially the full term of the assets or liabilities.
- Level 3 — inputs that are unobservable for the particular asset or liability due to little or no market activity and are significant to the fair value of the asset or liability. These inputs reflect assumptions that market participants would use when valuing the particular asset or liability.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS (continued)

D. Fair Value Measurements – continued

ASC Topic No. 820 requires a description of the methodologies used to measure the fair value of assets and liabilities. These methodologies were consistently applied to all assets carried as of December 31, 2008. The methodology used to measure each major category of assets are as follows:

- Mutual funds are presented at fair value based on the Net Asset Value (NAV) as of the close of each business day. This unadjusted quoted prices are readily observable in active markets. As such, these are categorized as Level 1 within the fair value hierarchy.
- Participant loans are valued at the outstanding principal balance, which approximates fair value and are classified within Level 3 of the valuation hierarchy.

The Plan had no assets at January 1, 2009 and accordingly no classification within the valuation hierarchy is required. As of December 31, 2008 investments were classified as follows. The Plan had no assets classified within Level 2 of the valuation hierarchy.

Fair Value Measurements at December 31, 2008 Using:			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 3)	Total
Mutual funds	\$ 149,771	\$ -	\$ 149,771
Participant loans	-	2,500	2,500
Total assets at fair value	\$ 149,771	\$ 2,500	\$ 152,271

The following table summarizes the changes in the fair value of the Plan's level 3 investments for the periods ended:

	January 1, 2009	December 31, 2008
Beginning balance	\$ 2,500	\$ 7,038
Purchases, sales, issuances, and settlements (net)	-	(4,538)
Transfer to another plan	(2,500)	-
Ending balance	\$ -	\$ 2,500

E. Tax Status

The Plan is a prototype plan which received an opinion letter from the Internal Revenue Service as to its tax-qualified status dated March 31, 2008. The Company does not have a separate determination letter for the Plan. The Plan Administrator believes that the Plan was designed and being operated in compliance with the applicable requirements of the Code for the period ended January 1, 2009 and for the year ended December 31, 2008.

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS (continued)

F. Plan Termination

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. All assets of the Plan would be distributed to the participants at the discretion of the Plan Sponsor or continue to be held in the trust fund to be distributed to each participant upon retirement, death, permanent disability, or termination of employment.

G. Information Certified by the Trustee

The Plan Administrator elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the Plan Administrator limited auditing procedures with respect to the investment information certified by the trustee, which included total investments as of December 31, 2008 and the total investment income (loss) for the period ended January 1, 2009 and for the year ended December 31, 2008.

H. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits as of December 31, 2008, per the accompanying financial statements to the Form 5500:

Net assets available for benefits per the financial statements	\$ 152,410
December 31, 2008 receivable	(139)
Net assets available for benefits per the Form 5500	<u>\$ 152,271</u>

There were no reconciling items as of December 31, 2009.

The following is a reconciliation of the net decrease in net assets available for benefits for the period ended January 1, 2009 and for year ended December 31, 2008, respectively, per the accompanying financial statements to the Form 5500:

	<u>2009</u>	<u>2008</u>
Net decrease in assets available for benefits per the financial statements	\$ (152,410)	\$ (223,333)
Participant contributions receivable as of December 31, 2007	-	3,263
Participant contributions receivable as of December 31, 2008	139	(139)
Transfer of assets from this Plan	<u>146,343</u>	<u>-</u>
Net decrease in net assets available for benefits per the Form 5500	<u>\$ (5,928)</u>	<u>\$ (220,209)</u>

ALPINE HOME HEALTH INC. 401(K) & PROFIT SHARING PLAN

NOTES TO FINANCIAL STATEMENTS (*continued*)

H. Reconciliation of Financial Statements to Form 5500 – continued

The reconciling items noted above are the result of the difference in the method of accounting used in preparing the Form 5500 as compared to the Plan's financial statements. The cash basis of accounting was used in preparing the Plan year 2009 and 2008 Form 5500, whereas the Plan's financial statements have been prepared on the accrual basis of accounting as required under accounting principles generally accepted in the United States of America.

I. Subsequent Events

In preparing the accompanying financial statements, management of the Plan Sponsor has evaluated all subsequent events and transactions for potential recognition or disclosure through March 17, 2011, the date the financial statements were available for issuance.