Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

HERE

Signature of DFE

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2009

This Form is Open to Public

					Inspection	10110	
Part I	Annual Report Identi	ification Information					
For cale	ndar plan year 2009 or fiscal pla	an year beginning 01/01/2009		and ending 12/31/20	009		
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or			
a single-employer plan; a DFE (specify)				pecify)			
		_	<u>—</u>				
B This	return/report is:	the first return/report;	the final r	eturn/report;			
		an amended return/report;	a short pl	an year return/report (less tha	an 12 months).		
C If the	nlan is a collectively-hardained	I plan, check here	ш .	• • •	<u> </u>		
				extension;	the DFVC program;		
D Chec	k box if filing under:	X Form 5558;	_	extension,	Ine DrvC program;		
		special extension (enter des					
Part	II Basic Plan Informa	ation—enter all requested informa	ition			1	
	ne of plan				1b Three-digit plan	001	
ENDION	I MEDICAL SERVICES, PC 40°	1(K)/PROFIT SHARING PLAN			number (PN) ▶ 1c Effective date of place	<u> </u>	
					01/01/2007	an	
2a Plar	sponsor's name and address	(employer, if for a single-employer p	olan)		2b Employer Identification		
	ress should include room or sui		,		Number (EIN)		
ENDION	I MEDICAL SERVICES, PC				20-1993401		
					2c Sponsor's telephone		
					number 585-344-7269		
	BUFFALO ROAD RD PARK, NY 14127		JFFALO ROAD D PARK, NY 14127		2d Business code (see		
OROHA	NOT ANN, NT 14121	OKCHARI	J FARR, NT 14121		instructions)		
					621111		
Caution	· A penalty for the late or inco	omplete filing of this return/repor	t will be assessed i	inless reasonable cause is	established		
	•	nalties set forth in the instructions, I				dules	
		the electronic version of this return					
SIGN	Filed with authorized/valid elec	etronic signature.	08/28/2010	JOHN BRACH MD			
HERE	Signature of plan administr	ator	Date	Enter name of individual sig	ning as plan administrator		
	Olynatare of plan administr	u.c.	Date	Emoi name of marvidual sig	grang do pian duministrator		
SIGN	Filed with authorized/valid elec	etronic signature.	08/28/2010	JOHN BRACH MD			
HERE				Enter name of individual size	ming on amplayor or also se		
	Signature of employer/plan	sponsor	Date	Enter name of individual sig	ning as employer or plan sp	108110	
SIGN							

Date

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

Form 5500 (2009) v.092307.1

Enter name of individual signing as DFE

	Form 5500 (2009) Page 2		
EN 420	Plan administrator's name and address (if same as plan sponsor, enter "Same") IDION MEDICAL SERVICES, PC 01 N BUFFALO ROAD RCHARD PARK, NY 14127	3c Ac	dministrator's EIN -1993401 dministrator's telephone umber 5-344-7269
4 a	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 the plan number from the last return/report: Sponsor's name	l and	4b EIN 4c PN
5	Total number of participants at the beginning of the plan year	5	13
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		1
а	Active participants	. 6a	13
b	Retired or separated participants receiving benefits	. 6b	0
С	Other retired or separated participants entitled to future benefits	. 6c	0
d	Subtotal. Add lines 6a, 6b, and 6c	. 6d	13
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	. 6е	0
f	Total. Add lines 6d and 6e	. 6f	13
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	. 6g	1
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	
b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Code 2E 2G 2J 3D 3H If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in	n the ins	tructions:
	Plan funding arrangement (check all that apply) (1)	insurano ponsor	ce contracts
	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the num Pension Schedules (1) R (Retirement Plan Information) B General Schedules (1) H (Financial Inform		oned. (See Instructions)

(2)

(3)

(4)

(5)

(6)

I (Financial Information – Small Plan)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

A (Insurance Information)C (Service Provider Information)

(2)

(3)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2009

nursuant to EDICA continu 100(a)(0)						Inspection
For calendar plan year 200	09 or fiscal pla	n year beginning 01/01/2009		and ending 1	2/31/2009	•
A Name of plan ENDION MEDICAL SERV	/ICES, PC 401	(K)/PROFIT SHARING PLAN	В	Three-digit plan number (PN) 🕨	001
C Plan sponsor's name a ENDION MEDICAL SERV	/ICES, PC		:	20-1993401	fication Number (I	
on a separat		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca						
	(c) NAIC	(d) Contract or	(e) Approximate numbe		Policy or co	ntract year
(b) EIN	code	identification number	persons covered at end policy or contract yea		f) From	(g) To
31-4156830	66869	0000ENDI00NY00K	3	01/01/2	2009	12/31/2009
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. List in	item 3 the agen	ts, brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		0				0
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all person	ons).		
	(a) Name a	and address of the agent, broker	, or other person to whom cor	mmissions or fee	es were paid	
(b) Amount of sales ar	nd base	Fe	es and other commissions pa	iid		
commissions pai	d	(c) Amount	(d) P	urpose		(e) Organization code
	(a) Name a	and address of the agent, broker	, or other person to whom co	mmissions or fee	es were paid	
		.				
(b) Amount of sales ar	nd base	Fe	es and other commissions pa	id		
commissions pai		(c) Amount	(d) P	urpose		(e) Organization code

Schedule A (Form 5500)	2009	Page 2- 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	dual contract	s with each carrier ma	y be treated as	s a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		. 4	0
		ent value of plan's interest under this contract in separate accounts at year er			. 5	58563
_		roots With Allocated Funds:				
	а	State the basis of premium rates NOT PROVIDED BY INSURANCE CO	MPANY			
					01	00075
	b	Premiums paid to carrier			. 6b	22875
	C	Premiums due but unpaid at the end of the year			. 6c	0
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	. 6d	923
		Specify nature of costs CONTRACT COMMISSIONS				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	I annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan ch	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts mai	ntained in se	parate accounts)		
	а	Type of contract: (1)	te participatic	on guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
					7.(0)	
	ا ام	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6)).			. 7d	
		Deductions:	70/1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 10(4)			
		•				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			. 7f	

Page 4	

Schedule A	(Form	5500	2000
Scriedule A	(FOIIII	5500	1 2009

Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting put the entire group of such individual contracts of	oup of employees of the surposes if such contracts	are experienc	ce-rated as a unit. Who	ere contract	
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	ty g	Supplemental unemp	oloyment	h Prescription drug
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	rience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	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)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs					
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n 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)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in c(2) .)		9e	
10		nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			10a	
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,		•	10b	
	Sp	ecify nature of costs					

Part IV	Provision of Information			
11 Did th	e 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 I (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Financial Information—Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

Totalion Bononic Guaranty Golporation	inspection	
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009	and ending 12/31/2009	
A Name of plan ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHARING PLAN	B Three-digit 001 plan number (PN) ▶	
C Plan sponsor's name as shown on line 2a of Form 5500 ENDION MEDICAL SERVICES, PC	D Employer Identification Number (EIN) 20-1993401	

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

Part I Small Plan Financial Information

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

1	Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
а	Total plan assets	. 1a	32141	72970
b	Total plan liabilities	. 1b	0	0
С	Net plan assets (subtract line 1b from line 1a)	1c	32141	72970
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
а	Contributions received or receivable:			
	(1) Employers	2a(1)	5788	
	(2) Participants	. 2a(2)	23150	
	(3) Others (including rollovers)	. 2a(3)	0	
b	Noncash contributions	. 2b	0	
С	Other income	. 2c	11921	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		40859
е	Benefits paid (including direct rollovers)	. 2e	0	
f	Corrective distributions (see instructions)	. 2f	0	
g	Certain deemed distributions of participant loans (see instructions)	. 2g	0	
h	Administrative service providers (salaries, fees, and commissions).	. 2h	0	
i	Other expenses	. 2i	30	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	. 2j		30
k	Net income (loss) (subtract line 2j from line 2d)	. 2k		40829
	Transfers to (from) the plan (see instructions)	. 2I		0

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

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

Schedule I (Form 5500) 2009	Page 2- 1

Schedule I	(Form	5500)	2000
Scriedule i	(FOIII)	ววบบ	2008

			Yes	No	Amou	nt
3f	Loans (other than to participants)	3f		X		_
g	Tangible personal property	3g		Χ		
				'.		
Pa	art II Compliance Questions					
4	During the plan year:		Yes	No	Amou	int
а	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		
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X		
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X		
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X		
е	Was the plan covered by a fidelity bond?	4e	X			10000
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 at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X		
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X		
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X			
ı	Has the plan failed to provide any benefit when due under the plan?	41		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				
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	Y	es 🛚 N	lo i	Amount:	
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.)	entify t	he plan	(s) to w	hich assets or liabil	ties were
	5b(1) Name of plan(s)			5b(2)	EIN(s)	5b(3) PN(s)

5500 Electronic Filing Authorization

Plan Name:

ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHARING PLAN

EIN/PN:

20-1993401/001

Plan Year:

01/01/2009 - 12/31/2009

I hereby authorize Anthony S. Asterino, CPA to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500 for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan Administrator

(sign)

V 8.27.10

(date)

Plan Sponson

(sign)

/8.27.10

(date)

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

> ► Complete all entries in accordance with the Instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2009

resision benefit obstanty corporati				This Form is Open to Public Inspection		
Part I Annual Re	port Identification Informatio	n				
For the calendar plan year	ar 2009 or fiscal plan year beginning	01/01/2009	and ending 12/3	1/2009		
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 rel	um/report (less than 12 months).		
C If the plan is a collective	ely-bargained plan, check here			▶□		
D Check box if filing under	r: 🔀 Form 5558;		automatic extension	; Ithe DFVC program;		
	special extension (enter des	cription)				
Part II Basic Plan	Information enter all request	ed information.				
1a Name of plan			-	1b Three-digit plan		
ENDION MEDICAL	SERVICES, PC 401(K)/PROFIT	SHARING PLAN		number (PN) ► 001		
				1c Effective date of plan 01/01/2007		
2a Plan sponsor's name	and address (employer, if for a single-e	mployer plan)		2b Employer Identification		
(Address should inclu	ude room or suite no.)			Number (EIN)		
ENDION MEDICAL	SERVICES, PC			20-1993401		
	·			2C Sponsor's telephone		
				number		
				(585) 344-7269 2d Business code (see		
4201 N BUFFALO	ROAD			instructions)		
US ORCHARD PAI	RK NY 14127			621111		
US ORCHARD PAR	W NI 1412,					
Caution: A penalty for the	late or incomplete filing of this retur	n/report will be assessed	d unless reasonable cause	is established.		
Under penalties of periury a	nd other penalties set forth in the instru	ctions. I declare that I have	e examined this return/report	t, including accompanying schedules.		
statements and attachment	s, as well as the electronic version of thi	is return/report, and to the	best of my knowledge and b	elief, it is true, correct, and complete.		
SIGN	H (Au)	8.27.10	JOHN A. BRACH, MD			
	an administrator	Date	Enter name of individual s	igning as plan administrator		
SIGN HERE	of (My)	8.27.10	JOHN A. BRACH, MD			
	mployer plan sponsor	Date	Enter name of individual s	igning as employer or plan sponsor		
SIGN HERE						
Signature of I	OFE	Date	Enter name of individual s	igning as DFE		

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

Form 5500 (2009) v.092307.1

	Form 5500 (2009)				Pa	qe	2				_			
	Plan administrator's name and address (if same as plan sponsor, enter "Same	e")									-		3b A	Administrator's EIN
												-		Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last return/n	report f	iled	fo	r ti	nis (olan,	ent	er th	e na	ıme,	EIN a	and	4b EIN
а	the plan number from the last return/report: Sponsor's name								•					4c PN
 5	Total number of participants at the beginning of the plan year												5	13
	Number of participants as of the end of the plan year (welfare plans complete									•	• •	\dashv		13
U	number of participants as of the end of the plantyear (wettare plants complete	Utily ili	169 (ua	, 0	υ, τ	rt ai	iu o	u,			ŀ		
а	Active participants		•	•	•	•	•		•	•		•	6a	13
b	Retired or separated participants receiving benefits			•	•				•			•	6b	0
C	Other retired or separated participants entitled to future benefits		•	•	•	•	•	• •	•	•		\cdot	6c	0
d	Subtotal. Add lines 6a, 6b and 6c		•	•	•	•	•	• •	•	•		\cdot	6d	13
е	Deceased participants whose beneficiaries are receiving or are entitled to rece	eive be	nefit	ts		•	•	• •	•	•			6e	0
f	Total. Add lines 6d and 6e	• •	•	•	•	٠	٠	• •	•	•		•	6f	13
g	Number of participants with account balances as of the end of the plan year (o complete this item)	nly de	fined	d c	or	ntrib •	utior •	n pla	ns				6g	1
h	Number of participants that terminated employment during the plan year with a 100% vested												6h	0
<u>7</u>	Enter the total number of employers obligated to contribute to the plan (only m											$\overline{\cdot}$	7	
8a	If the plan provides pension benefits, enter the applicable pension feature coo	des fro	m th	ne	Lis	st o	Pla	n C	narac	cteri	stic C	odes	in th	e instructions:
b	2E 2G 2J 3D 3H If the plan provides welfare benefits, enter the applicable welfare feature code	es fron	n the	e L	.ist	of	Plan	Ch	aract	erisi	tic Co	odes	in the	instructions:
9a	Plan funding arrangement (check all that apply)	9b F	lan	be	ne	efit a	ırran	gen	nent	(che	ck al	l that	appl	у)
	(1) X Insurance	-	1)	Ц	i		ance							
	(2) Code section 412(e)(3) insurance contracts	•	2)	Ц				tion	412	(e)(3) ins	uran	ce co	ntracts
	(3) X Trust		3) 4)	Ř		rus				. dla a				
10	(4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are at			LJ Id.							spor		er at	tached. (See instructions)
a		_							, v					
a		_			11 C	cn	edui		/Eina	ncis	ıl (nfe	rmat	ion)	
	(1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money		1) 2)	×								rmat rmati		Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan			X			1					orma		umaii i idii)
	actuary		4)	Ħ	١.		_							nation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	•	5)	П					•					Information)
	Information) - signed by the plan actuary		6)		ĺ			G	(Fina	ncia	al Tra	nsac	tion l	nformation)

Sponsor Location Information

Sponsor name:

ENDION MEDICAL SERVICES, PC

Sponsor DBA name: Sponsor care of name:

4201 N Buffalo Road

US Orchard Park

NY 14127

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under sections 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

► File as an attachment to Form 5500.

► Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

For calendar plan ye	ar 2009 or fiscal p	lan year beginning 01/01/2	009	and ending	12/31/2	009		
A Name of plan				B Three-di	git nber (PN)	_		
ENDION MEDICAL	SERVICES, PC	401(K)/PROFIT SHARING	PLAN	pierrica			001	
C Plan sponsor's n	ame as shown on	line 2a of Form 5500.		D Employe	er Indentification	Number (E	IN)	
NDION MEDICAL	SERVICES. PC				20-199340)1		
Part I Inform	ation Concer	ning Insurance Contract						
1 Coverage Inform	nation:							
(a) Name of insurance	ce carrier							
ATIONWIDE LIFE	INSURANCE C	0.						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate persons covere			Policy or	contract year	
(6) 2.11	code	identification number	policy or cont		(f) From		(g) To	
31-4156830	66869	0000END100NY00K		3	1/1/2009		12/31/2009	
	nd commission info	ormation. Enter the total fees and aid.	total commissions pai	d. List in item	3 the agents, br	okers, and	other persons in	
(a)	Total amount of c	ommissions paid		(b) Tota	al amount of fees	paid		
		0				0		
3 Persons receiving	ig commissions ar	nd fees. (Complete as many entri	ies as needed to report	all persons).				
	(a) Name a	and address of the agent, broker,	, or other person to wh	om commissi	ons or fees were	paid		
·			 					
(b) Amount of s			es and other commissi				(a) Comprised to a code	
commission	ons paid	(C) Amount		(d) Purpose	<u> </u>		(e) Organization code	
							and the second s	
	(a) Name a	and address of the agent, broker,	, or other person to wh	om commissi	ons or fees were	paid		
(b) Amount of s	ales and base	Fee	es and other commissi	ons paid				
commission		(C) Amount		(d) Purpose)		(e) Organization code	
						Į		
						1		

Schedule A (Form 5500) 2009	Page 2-	
(a) Nam	e and address of the agent, bro	oker or other person to whom commissions or fees were p	paid
(b) Amount of sales and base		Fees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Narr	e and address of the agent, bro	oker or other person to whom commissions or fees were p	paid
	<u> </u>	Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nam	e and address of the agent, bro	oker or other person to whom commissions or fees were p	oaid
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Nam	a and address of the agent, ha	oker or other person to whom commissions or fees were p	vaid
(b) Amount of sales and base		Fees and other commissions paid	4.3.000.0000000000000000000000000000000
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Nam	e and address of the agent, bro	oker or other person to whom commissions or fees were p	paid
(h) Amount of colon and have	<u> </u>	Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code

Pa	ert II Investment and Annuity Contract Information		
	Where individual contracts are provided, the entire group of such individual contracts with each carrier mathis report.	y be treate	d as a unit for purposes of
4	Current value of plan's interest under this contract in the general account at year end	4	0
5	Current value of plan's interest under this contract in separate accounts at year end	5	58,563
6	Contracts With Allocated Funds: a State the basis of premium rates ► NOT PROVIDED BY INSURANCE COMPANY		
	b Premiums paid to carrier	6b	22,875
	C Premiums due but unpaid at the end of the year	6c	0
	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	923
	Specify nature of costs ►		
	CONTRACT COMMISSIONS e Type of contract (1) x 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)		
а	Type on contract (1) deposit administration (2) immediate participation guarantee		
	(3) ☐ guaranteed investment (4) ☐ other ►		
t	Balance at the end of the previous year	7b	
C	Additions: (1) Contributions deposited during the year		
	(2) Dividends and credits		
	(3) Interest credited during the year		
	(4) Transferred from separate account		
	(5) Other (specify below)	27/12/2014	
	(6) Total additions	7c(6)	
	Total of balance and additions (add b and c(6))	7d	(ozrosičinimi militarnostroma) (22.5)
е		31249-07227-1237	
	(1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier		
	(2) Administration charge made by carrier		
	(4) Other (specify below)		
	ty one (speak) below		
		7e(5)	
£	(5) Total deductions	76(5) 7f	
1	Dalance at the end of the corrent year (Subtractets) from 0).		

Page	4
1 046	_

Pa	rt III Welfare Benefit Contract Informa	tion			
	If more than one contract covers the same gro information may be combined for reporting pur the entire group of such individual contracts w	poses if such contracts are exp	perience-rated as a unit. W	here contracts	
8	Benefit and contract type (check all applicable boxes)			
_	a Health (other than dental or vision)	Ď Dental	c Vision	1	d Life insurance
	e Temporary disability (accident and sickness)	f Long-term disability	g Supplemental uner	nplovment	h Prescription drug
	i Stop loss (large deductible)	j HMO contract	k PPO contract		I Indemnity contract
	m Other (specify) ►) I Timo contract	н 📑 г г о оолшио		
9	Experience-rated contracts				
а	Premiums: (1) Amount received		9a(1)		
	(2) Increase (decrease) in amount due but unpaid		9a(2)		
	(3) Increase (decrease) in unearned premium reser	ve	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)	
	• • • • • • • • • • • • • • • • • • • •			9b(4)	
C	Remainder of premium: (1) Retention charges (on a	nn 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) 9c(1)(F)		-
	(F) Charges for risks or other contingencies		9c(1)(G)		
	(G) Other retention charges		30(1)(0)	9c(1)(H)	
	(H) Total retention		or credited.	9c(2)	
d				9d(1)	
u	(2) Claim reserves	amount held to provide benefits		9d(2)	
	(3) Other reserves			9c(3)	
е				9e	
10					
а		er		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 reporte			10b	
S	pecify nature of costs ▶				
- B-	nt IV Dravision of Information				· · · · · · · · · · · · · · · · · · ·
	art IV Provision of Information	tion necessary to complete Sale	nedule A2	/es	No
11	Did the insurance company fail to provide any informa	non necessary to complete Scr	icanic V: • • •	100	

SCHEDULE I (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

For	calendar plan year 2009 or fiscal plan year beginning 01/01/2009		and ending	12/3	31/2009		
Α	Name of plan			B Thre	e-digit		
	ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHARING PLAN					•	001
			i i				
С	Plan sponsor's name as shown on line 2a of Form 5500			D Emp	loyer Iden	tification	on Number (EIN)
	ENDION MEDICAL SERVICES, PC			20-	1993401		
Comp	lete Schedule I if the plan covered fewer than 100 participants as of the beginning	g of the plan	year. You m	ay also c	omplete S	chedu	le I if you are filing as a
small	plan under the 80-120 participant rule (see instructions). Complete Schedule H i	reporting as	a large plan	or DFE.	•		
Pa	art I Small Plan Financial Information						
asset: benef	t below the current value of assets and liabilities, income, expenses, transfers at sheld in more than one trust. Do not enter the value of the portion of an insurance at at a future date. Include all income and expenses of the plan including any true ince carriers. Round off amounts to the nearest dollar.	e contract th	at guarantee:	s during (his plan ye	ear to	pay a specific dollar
1	Plan Assets and Liabilities:		(a) Beginnin	ng of Yea	г	(b)	End of Year
а	Total plan assets	1a			32,141		72,970
b	Total plan liabilities	1b			0		0
С	Net plan assets (subtract line 1b from line 1a)	1c			32,141		72,970
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amou	unt			(b) Total
а							_
	(1) Employers	2a(1)			5,788		
	(2) Participants	2a(2)		:	23,150		
	(3) Others (including rollovers)	2a(3)			0		
b		2b			0		
C	Other income	2c		:	11,921		
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d					40,859
е	Benefits paid (including direct rollovers)	2e			0		
f	Corrective distributions (see instructions)	2f			0		
g	Certain deemed distributions of participant loans						
Ū	(see instructions)	2g			0		
h	Administrative service providers (salaries, fees, and commissions)	2h			0		
i	Other expenses	2i			30		
j	Total expenses (add lines 2e, 2f, 2g, 2h and 2i)	2 <u>j</u>			1		30
k	Net income (loss) (subtract line 2j from line 2d)	2k			L		40,829
1	Transfers to (from) the plan (see instructions)	21					0
3	Specific Assets: If the plan held assets at anytime during the plan year in any of the fol remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest by-line basis unless the trust meets one of the specific exceptions described in the instruction	in a comming	ies, check "Yes led trust contair	" and ente ning the as	r the current sets of more	t value e than c	of any assets one plan on a line-
				Yes	No		Amount
а	Partnership/joint venture interests		3a		х		
	Employer real property				х		
c	Real estate (other than employer real property)				х		
d					х		
	Participant loans)	х		· · · · · · · · · · · · · · · · · · ·
Foi	Paperwork Reduction Act Notice and OMB Control Numbers, see the Insti	ructions for	Form 5500.			Sched	iule I (Form 5500) 2009 v.092308

	Schedule I (Form 5500) 2009	Pag	e 2- 🗌		
3f	Loans (other than to participants)	3f	Yes	No X	Amount
g	Tangible personal property	3g		x	
Part II			l	T	1
4	During the plan year:	ři serval	Yes	No	Amount
а	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	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	4b		x	
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		x	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		х	
e	Was the plan covered by a fidelity bond?	4e	х		10,000
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		х	
ħ	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 at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		x	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		x	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No", attach the IQPA's report or 2520.104-50 statement. (See Instructions on waiver eligibility and conditions.)	4k	x		2
1	Has the plan failed to provide any benefit when due under the plan?	41		х	
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			
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	Amoun	t:
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify transferred. (See instructions.)	fy the pla	an(s) to v	vhich ass	ets or liabilities were
	5b(1) Name of plan(s)	5	b(2)	EIN(s)	5b(3) PN(s)

Form 5558 (Rev. January 2008) Department of the Treasury Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions on page 3.

OMB No. 1545-0212

Form **5558** (Rev. 1-2008)

File With IRS Only

Par	t I Identification							
A	Name of filer, plan administrator, or plan sponsor (see instructions) ENDION MEDICAL SERVICES, PC	B	B Filer's identifying number (see instructions). Employer identification number (EIN). 20-1993401 Social security number (SSN)					
	Number, street, and room or suite no. (If a P.O. box, see instructions.)							
	4201 N BUFFALO ROAD							
	City or town, state and ZIP code	j						
	ORCHARD PARK NY 14127							
C	Plan name		Plan		Plan year ending-			
			numb	er	MM	DD	YYYY	
1	ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHA	0	0	 1 	12	31	2009	
2			i I			<u> </u>		
3			 					
Part	Extension of Time to File Form 5500 or Form 5500-EZ	(see inst	ructio	ns)				
1	I request an extension of time until 10 / 15 / 2010 to file Form 5500 or Form 5500-EZ.							
	The application is automatically approved to the date shown on line 1 (above) if: (a) the Form 5558 is filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and (b) the date on line 1 is no more the 2 1/2 months after the normal due date.							
	You must attach a copy of this Form 5558 to each Form 5500 and 5500-	EZ filed af	ter the	due d	late for the p	plans listed	in C above.	
lote.	A signature is not required if you are requesting an extension to file Form 550	0 or Form	5500-	EZ.				
Dard	Extension of Time to File Form 5330 (see instructions)							
CIL	Extension of Time to the Form 3550 (See mandations)							
	I request an extension of time until to file Form 5330, a			lue dat	e of Form 53	330.		
а	Enter the Code section(s) imposing the tax	. •	a					
b	Enter the payment amount attached				•	b		
с 3	For excise taxes under section 4980 or 4980F of the Code, enter the revision/amendment date							
•								
-					·			
-								
-								
-								
-								
-								
-	. 0							
-								
nder p	enalties of perjury. I declar inhat to the best of my knowledge and belief the statements	s made on t	his form	n are tru	e, correct, an	d complete, ar	nd that I am	
uthoriz	ed to prepare this application.			4	16/20	1.75		
anat	ure ▶ /()K//M//)ate ▶		WILO	10		