Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public

				Inspection				
Part I	Annual Report Ident	tification Information						
For cale	ndar plan year 2010 or fiscal p			and ending 12/31/20	10			
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or				
	·	X a single-employer plan;	a DFE (s	pecify)				
				· · · · · · · · · · · · · · · · · · ·				
B This	return/report is:	the first return/report;	the final r	eturn/report;				
		an amended return/report;	a short pl	lan year return/report (less tha	n 12 months).			
C If the	plan is a collectively-bargaine	d plan, check here	_					
	k box if filing under:	Form 5558;	_	c extension;	the DFVC program;			
	3 * * * *	special extension (enter desc	cription)					
Part	Part II Basic Plan Information—enter all requested information							
1a Nam	ne of plan	,			1b Three-digit plan	001		
ENDION	MEDICAL SERVICES, PC 40	01(K)/PROFIT SHARING PLAN			number (PN) ▶			
		1c Effective date of plan 01/01/2007						
2a Plan sponsor's name and address (employer, if for a single-employer plan)					2b Employer Identification			
(Address should include room or suite no.) ENDION MEDICAL SERVICES, PC				Number (EIN) 20-1993401				
LINDION	TWEDICAL SERVICES, I C				2c Sponsor's telephor	 1е		
					number			
4201 N E	BUFFALO ROAD	4201 N BL	JFFALO ROAD		585-344-7269			
ORCHAI	RD PARK, NY 14127	ORCHARI	D PARK, NY 14127		2d Business code (see instructions)	Э		
					621111			
Caution	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	Filed with authorized/valid elec	ctronic signature.	10/04/2011	JOHN A BRACH MD				
HERE	Signature of plan administ	rator	Date	Enter name of individual sig	ning as plan administrator			
					J - J - J - J - J - J - J - J - J - J -			
SIGN	Filed with authorized/valid ele	ctronic signature.	10/04/2011	JOHN A BRACH MD				
HERE				 				

Date

Date

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

Signature of employer/plan sponsor

Signature of DFE

SIGN **HERE**

> Form 5500 (2010) v.092307.1

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

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	Plan administrator's name and address (if same as plan sponsor, enter "San DION MEDICAL SERVICES, PC	ne")		Iministrator's EIN 1993401
	01 N BUFFALO ROAD CHARD PARK, NY 14127		nι	Iministrator's telephone Imber 5-344-7269
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for this plan, enter the name, EIN	and	4b EIN
а	Sponsor's name			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	e only lines 6a, 6b, 6c, and 6d).		
а	Active participants		6a	14
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	14
•	Deceased participants whose beneficiaries are receiving or are entitled to re	aciva hanafita	6e	0
	Deceased participants whose beneficiaries are receiving of are entitled to re	ceive perients		
f	Total. Add lines 6d and 6e		6f	14
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g	2
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h	0
7	Enter the total number of employers obligated to contribute to the plan (only		7	
	If the plan provides pension benefits, enter the applicable pension feature con the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable pension feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits, enter the applicable welfare feature code to the plan provides welfare benefits and the plan provides welf			
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all tha	at apply)	
10	(1) Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor	(1) Insurance Code section 412(e)(3)	oonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the number	oer attac	cnea. (See instructions)
а	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	b General Schedules (1) H (Financial Inform (2) X I (Financial Inform (3) X 1 A (Insurance Inform (4) C (Service Provide	nation – mation) er Inform	nation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participati (6) G (Financial Trans	•	,

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.

OMB No. 1210-0110

2010

1 choich belieft duaranty oc	riporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			tion	This Form is Open to Public Inspection		
For calendar plan year 20	10 or fiscal pla	an year beginning 01/01/2010)	and er	nding 12/31	/2010		
A Name of plan ENDION MEDICAL SERV	/ICES, PC 40	1(K)/PROFIT SHARING PLAN			e-digit number (PN)	•	001	
C Plan sponsor's name a ENDION MEDICAL SERV		ne 2a of Form 5500.		D Emplo	oyer Identification	on Number	(EIN)	
		ning Insurance Contract. Individual contracts grouped a						
(a) Name of insurance ca								
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate r persons covered policy or contra	at end of	(f) Fr	•	(g) To	
31-4156830	66869	0000ENDI00NY00K	policy of continu	2			12/31/2010	
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid.	_ist in item 3	the agents, br	okers, and	other persons in	
		nmissions paid		(b) To	otal amount of	fees paid	0	
2 Darragna ragaining com	missians and			I naraana)			0	
3 Persons receiving com		fees. (Complete as many entried and address of the agent, broke			·			
(b) Amount of sales ar			ees and other commission			sio paid		
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	om commiss	ions or fees we	ere paid		
	(a) Name	and address of the agent, broke	n, et eulet percent te wiik	<u> </u>		sio paia		
(b) Amount of sales ar	nd hase		ees and other commission	ons paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	

Schedule A (Form 5500)	2010	Page 2-		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code
	(o) runount		(a) i dipoco	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	ridual contracts	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	0
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	118753
_		roots With Allocated Funds:				
	а	State the basis of premium rates NOT PROVIDED BY INSURANCE CO	OMPANY			
	b	Premiums paid to carrier			6b	23552
	С	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	942
		Specify nature of costs CONTRACT COMMISSIONS				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participatio	n guarantee		
		(3) guaranteed investment (4) other	•			
		(4) 🗎 3 (4)				
	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)			
		>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add b and c(6))			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	- (-)			
		(4) Other (specify below)	7e(4)			
		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
		7				
					1	
	_	(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	เ ออบบ) ZUTU
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Pa	art II						
		If more than one contract covers the same ginformation may be combined for reporting p the entire group of such individual contracts.	urposes if such contracts	are experienc	ce-rated as a unit. Wh	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	а「	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	ployment	h Prescription drug
	ιĖ	Stop loss (large deductible)	j HMO contract	, J_ k□	PPO contract	, ,	I Indemnity contract
	m	=	,	L			
9	Evne	erience-rated contracts:					
•	•	Premiums: (1) Amount received		9a(1)			
	٠.	(2) Increase (decrease) in amount due but unpair		9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		- σα(. /	
	-	(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c		•••••		. 	
	·	(A) Commissions	,	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	•			9c(1)(H	
		(2) Dividends or retroactive rate refunds. (These	_				
	d	Status of policyholder reserves at end of year: (1					
	u	(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n				9e	
10		nexperience-rated contracts:	ot molade amount entered	· · · · · · · · · · · · · · · · · · ·		1 30	
•		Total premiums or subscription charges paid to	arrier			. 10a	
	b	If the carrier, service, or other organization incur				104	
		retention of the contract or policy, other than rep	, .		•	. 10b	
	Sp	ecify nature of costs					

Yes

No

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Provision of Information

Part IV

SCHEDULE I (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

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

2010

This Form is Open to Public Inspection

Ferision Benefit Guaranty Corporation	inspection
For calendar plan year 2010 or fiscal plan year beginning 01/01/2010	and ending 12/31/2010
A Name of plan ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHARING PLAN	B Three-digit plan number (PN) 001
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	72970	136943
b	Total plan liabilities	. 1b	0	
С	Net plan assets (subtract line 1b from line 1a)	1c	72970	136943
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
а	Contributions received or receivable:			
	(1) Employers	2a(1)	5025	
	(2) Participants	. 2a(2)	24340	
	(3) Others (including rollovers)	. 2a(3)	0	
b	Noncash contributions	. 2b	0	
С	Other income	. 2c	14238	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	. 2d		43603
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	60	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	. 2j		60
k	Net income (loss) (subtract line 2j from line 2d)	. 2k		43543
- 1	Transfers to (from) the plan (see instructions)	. 2I		20430

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	
С	Real estate (other than employer real property)	3с		X	
d	Employer securities	3d		X	
	Participant loans			X	

	Schedule I (Form 5500) 2010 Page 2-			_	
	_		Yes	No	Amount
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	
Pä	art II Compliance Questions				
	During the plan year:		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 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		Х	
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		Х	
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		Х	
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	_	es XI	No Am	ount:

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)

5500 Electronic Filing Authorization

Plan Name:

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

EIN/PN:

20-1993401/001

Plan Year:

01/01/2010 - 12/31/2010

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 Administra

(sign)

/ sl n tr n \

Plan Spons

(sign)

. . .

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

Part 1	Annual Report	Identification Information				
For the	calendar plan year 201	0 or fiscal plan year beginning 01	/01/2010	and ending 12/31	/2010	
A This	return/report is for:	a multiemployer plan;		a multiple-employer p	olan; 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 retu	m/report (less than 12 m	onths).
C If the	plan is a collectively-bar	gained plan, check here				. ▶□
D Chec	k box if filing under:	X Form 5558;		automatic extension;	the DFVC pr	ogram:
	<u>-</u>	special extension (enter description	on)			•
Part I	Basic Plan Info	rmation enter all requested in	nformation.			
<u> </u>	me of plan				1b Three-digit plan	
	•	VICES, PC 401(K)/PROFIT SH	HARING PLAN		number (PN) ▶	001
					1c Effective date of pla	n
					01/01/2007	
2a Pi	an sponsor's name and a	ddress (employer, if for a single-emplo	yer plan)		2b Employer Identificat	ion
(A	ddress should include roo	om or suite no.)			Number (EIN)	
EN	DION MEDICAL SER	VICES, PC			20-1993401	
					2C Sponsor's telephone	•
					number	_
42	01 N BUFFALO ROA				(585) 344-726	
42	OI N BUFFALO ROA	5			2d Business code (see instructions)	
บร	ORCHARD PARK	NY 14127			621111	
-						
Caution:	A penalty for the late of	r incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is	established.	
Under pe	nalties of perjury and oth	er penalties set forth in the instructions	s. I declare that I have	examined this return/report, i	ncluding accompanying s	chedules.
statemen	its and attachments, as v	ell as the electronic version of this retu	um/report, and to the	best of my knowledge and bel	ief, it is true, correct, and	complete.
SIGN	1 / 1/1/	$\mathcal{P}_{\mathbf{k}}$	10.4.11			
HERE				JOHN A. BRACH, MD	·	
	Signature of plan ac	Iministrator	Date	Enter name of individual sig	ning as plan administrato)F
SIGN	1 / ///H/	Mer.)	10.4.11	JOHN A. BRACH, MD		
neke	Signature of employ	ver/plan snonsor	Date	Enter name of individual sig	ming as employer or plan	2000001
SIGN					ning as employer or plan	эринзи
HERE						
	Signature of DFE		Date	Enter name of individual sig	ning as DFE	

_	Form 5500 (2010)		Pac	ge 2		
3a	Plan administrator's name and address (if same as plan sponsor, enter "Same"	")			3b .	Administrator's EIN
						Administrator's telephone number
						-
4	If the name and/or EIN of the plan sponsor has changed since the last return/rethe plan number from the last return/report:	eport file	ed for th	nis plan, enter the name, E	IN and	4b EIN
а	Sponsor's name					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 of					· · · · · · · · · · · · · · · · · · ·
а	Active participants				. 6a	14
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	14
8	Deceased participants whose beneficiaries are receiving or are entitled to recei	ive bene	efits		. 6e	0
f	Total. Add lines 6d and 6e				. 6f	14
g	Number of participants with account balances as of the end of the plan year (or complete this item)	nly defir	ed cont	tribution plans	. 6 g	2
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 mu				. 7	
8a	If the plan provides pension benefits, enter the applicable pension feature cod	les from	the List	t of Plan Characteristic Co	des in ti	ne instructions:
	2E 2G 2J 2K 3D 3H If the plan provides welfare benefits, enter the applicable welfare feature code.	s from t	he List (of Plan Characteristic Cod	es in the	e instructions:
9a				fit arrangement (check all t	hat app	ly)
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) (2)	\Box	surance ode section 412(e)(3) insul	ance co	intracto
	(3) X Trust	(3)	$\overline{}$	ust	ance co	initi acts
	(4) General assets of the sponsor	(4)		eneral assets of the spons	or	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are atta	ached, a				tached. (See instructions)
а	Pension Schedules b) Ge	neral Sc	chedules		
	(1) R (Retirement Plan Information)	(1)	П	H (Financial Infor	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	X	I (Financial Infom	nation -	Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	<u>×</u> _	1 A (Insurance Infor	mation)	
	actuary	(4)	Ц	C (Service Provide	er Inforn	nation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5)	Н	D (DFE/Participati	_	
	monimation; - agree of the plan actually	(6)	1 1	G (Financial Trans	sacubii I	160111146011)

Form 5500 (2010)

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 Emptoyee Benefits Security Administration Pension Benefit Guaranty Corporation 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 Information

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2). OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan yea	r 2010 or fiscal pl	an year beginning 01/01/	2010	and ending	12/31/2	2010	
A Name of plan				B Three-di plan nun	git nber (PN)	•	001
ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHARING PLAN							
C Plan sponsor's na	me as shown on	line 2a of Form 5500.		D Employe	r Indentification	Number (E	N)
ENDION MEDICAL S	•		·······		20-19934		
		ning Insurance Contra Individual contracts grouped as					formation for each contract
1 Coverage Informa	ition:						
(a) Name of insurance	carrier						
NATIONWIDE LIFE	Τ	0.	(e) Approximate	number of		Delieures	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covere	d at end of	(f) From	-	contract year (g) To
31-4156830	66869	0000ENDI00NY00K		2	1/1/2010		12/31/2010
2 Insurance fee and descending order		rmation. Enter the total fees an	d total commissions paid	d. List in item	3 the agents, bro	okers, and	other persons in
		ommissions paid		(b) Tota	I amount of fees	paid	
		0				0	
3 Persons receiving	commissions an	d fees. (Complete as many enti	ies as needed to report	all persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	om commissio	ons or fees were	paid	
(b) Amount of sa	les and base	Fe	ees and other commission	ons paid	· · · · · · · · · · · · · · · · · · ·		
commission		(C) Amount		(d) Purpose			(e) Organization code
The state of the s	(a) Name a	and address of the agent, broke	r, or other person to who	om commissio	ons or fees were	paid	
	(a) name o	and address of any agent, evene	., с. с		0. 1000 11010	P	
(b) Amount of sa	les and base		es and other commission				
commission	s paid	(C) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500	2010	Page 2-	
(a) Nan	e and address of the agent, bro	oker or other person to whom commissions or fees were	paid
(a) Name and address of the agent, broker or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount of sales and base commissions paid (d) Purpose (e) Amount of sales and base commissions paid (e) Amount of sales and base commissions paid (f) Amount of sales and base commissions paid (g) Name and address of the agent, broker or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (e) Amount of sales and base (e) Amount (f) Purpose (e) Organization code (b) Amount of sales and base (e) Amount (f) Purpose (e) Organization code (b) Amount of sales and base (e) Amount (f) Purpose (e) Organization code (b) Amount of sales and base (c) Amount (f) Purpose (e) Organization code (b) Amount of sales and base (c) Amount (f) Purpose (e) Organization code (b) Amount of sales and base (c) Amount (f) Purpose (e) Organization code (c) Amount of sales and base (c) Amount (f) Purpose (e) Organization code (b) Amount of sales and base (c) Amount (f) Purpose (e) Organization code (b) Amount of sales and base (c) Amount (f) Purpose (e) Organization code			
(h) Amount of color and hoos	1	Fees and other commissions paid	
		·	(e) Organization code
	(c)	(2)	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(a) Nan	ne and address of the agent, bro	oker or other person to whom commissions or fees were	paid
/h) Amount of cales and base		Fees and other commissions paid	
			(e) Organization code
(a) Nam	e and address of the agent, bro	oker or other nerson to whom commissions or fees were	e paid
			(e) Organization code
Spirit Arguitano			
(a) Nam	e and address of the agent, bro	oker or other person to whom commissions or fees were	paid
		·	(a) Outpatienting and
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	paid
(b) Amount of sales and base		Fees and other commissions paid	
	(c) Amount	(d) Purpose	(e) Organization code
	1	1	

700		Investment and Annuity Contract Information				
Pa	rt II	Where individual contracts are provided, the entire group of such indithis report.	vidual contr	acts with each carrier ma	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 yea	r end .		4	0
5		value of plan's interest under this contract in separate accounts at year			5	118,753
6	Contract a Stat	s With Allocated Funds: e the basis of premium rates PROVIDED BY INSURANCE COMPANY			<u>.</u>	
		niums paid to carrier			6b	23,552
		niums due but unpaid at the end of the year			6c	0
(e carrier, service, or other organization incurred any specific costs in contention of the contract or policy, enter amount	nnection wit	h the acquisition	6d	942
	Spe	cify nature of costs				
		TRACT COMMISSIONS				
(e Type (3)	e of contract (1) x individual policies (2) group deferred ar other (specify)	nuity			
		ntract purchased, in whole or in part, to distribute benefits from a termin			▶ []	
7		ts With Unallocated Funds (Do not include portions of these contracts				
а	Тур		mmediate p	articipation guarantee		
		(3) guaranteed investment (4)	other 🕨			
b	Balance	e at the end of the previous year			7b	
C	Additio	ns: (1) Contributions deposited during the year	7c(1)			
	(2) Divi	dends and credits	7c(2)			
	(3) Inte	rest credited during the year	7c(3)			
	• •	nsferred from separate account	7c(4)			
	(5) Oth	er (specify below)	7c(5)			
	>					
	(6) Tota	nl additions			7c(6)	
d e	Total of	balance and additions (add b and c(6)) · · · · · · · · · · ·			7d	
	(1) Dist	sursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Adn	ninistration charge made by carrier	7e(2)			
	(3) Tran	nsferred to separate account	7e(3)			
	(4) Oth	er (specify below)	7e(4)	· · · · · · · · · · · · · · · · · · ·		
	•					
			ľ			
					ľ	
	(5) Tota	Il deductions			7e(5)	·
f		e at the end of the current year (subtract e(5) from d).			7f	

P	20	۵	4
_	d٧	ıe	•

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

Pai	Welfare Benefit Contract Information			
:	If more than one contract covers the same group of employees of the same			
i .	information may be combined for reporting purposes if such contracts are ex			over individual employees,
	the entire group of such individual contracts with each carrier may be treated	u as a unit for purposes of thi	s report.	
8	Benefit and contract type (check all applicable boxes)	- D		ച ∏
	a Health (other than dental or vision)	C Vision		d Life insurance
	e Temporary disability (accident and sickness) f Long-term disability	g Supplemental uner	nployment	h Prescription drug
	i Stop loss (large deductible) j HMO contract	k PPO contract		Indemnity contract
	m∐ Other (specify) ►			
9	Experience-rated contracts			
a	Premiums: (1) Amount received	9a(1)		
-	(2) Increase (decrease) in amount due but unpaid	9a(2)		
	(3) Increase (decrease) in unearned premium reserve	9a(3)		
	(4) Earned ((1) + (2) - (3))		9a(4)	· · · · · · · · · · · · · · · · · · ·
b	Benefit charges: (1) Claims paid	9b(1)	1 3(.)	
-	(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 (on an accrual basis)			
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees	9c(1)(B)		
	(C) Other specific acquisition costs	9c(1)(C)		
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention		9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (The amounts were paid in cash	n, 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		9c(3)	
<u>e</u>	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		9e	
10	Nonexperience-rated contracts:			
а	Total premiums or subscription charges paid to carrier		10a	
b	If the carrier, service, or other organization incurred any specific costs in connection	n with the acquisition or		
	retention of the contract or policy, other than reported in Part I, item 2 above, report	tamount	10b	
Sp	ecify nature of costs >			
Total Service	COVAL Day of the council of			
	t V Provision of Information			<u></u>
<u> 11 ı</u>	Did the insurance company fail to provide any information necessary to complete Sci	hedule A? Y	es	No

SCHEDULE I (Form 5500)

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

OMB No. 1210-0110

	Department of the Treasury Internal Revenue Service	Retirement Income Security Act of 197 Internal Revenue	74 (ERISA)	and section 6			;	2010
E	Department of Labor imployee Benefits Security Administration Pension Benofit Guaranty Corporation	▶ File as an attachm	ent to For	m 5500.				is Open to Public
For	calendar plan year 2010 or fiscal plan	year beginning 01/01/2010		and endin	g 12/3	31/2010		
A	Name of plan				B Thre	e-digit		
	ENDION MEDICAL SERVICES,	PC 401(K)/PROFIT SHARING PLAN	N			number	•	001
					i i i i i i i i i i i i i i i i i i i			
						- 846 	· · · · · · · · · · · · · · · · · · ·	<u> </u>
C	Plan sponsor's name as shown on line						tification Nun	nber (EIN)
	ENDION MEDICAL SERVICES,					1993401		
Comp	plete Schedule I if the plan covered few plan under the 80-120 participant rule	ver than 100 participants as of the beginnin (see instructions). Complete Schedule H if	g of the plac reporting a	n year. You m	nay also co	omplete S	chedule I if yo	ou are filing as a
	art I Small Plan Financial		reporting a	a large plan	O DFE.			
		d liabilities, income, expenses, transfers an						
benef insura	it at a future date. Include all income a ance carriers. Round off amounts to t	enter the value of the portion of an insurance and expenses of the plan including any trus the nearest dollar.	e contract ti	rately mainta	ined fund(s) and any	payments/re	eceipts to/from
1_	Plan Assets and Liabilities:	}	<u> </u>	(a) Beginni			(b) End of	
a	Total plan assets		<u> 1a</u>		7	2,970		136,943
b	•		<u>1b</u>			0		
<u>_c</u>		n line 1a)	<u>1c</u>		7	2,970		136,943
2	Income, Expenses, and Transfe	rs for this Plan Year:		(a) Amo	ount		(b) To	tal
а	Contributions received or receivable							
	(1) Employers		2a(1)			5,025	- a-, 1	
	''		2a(2)		2	4,340		
	• • • •		2a(3)					
þ	Noncash contributions		<u>2b</u>					
C	Other income		2c		1	4,238	<u> </u>	
d	Total income (add lines 2a(1), 2a(2),	F	<u>2d</u>		·			43,603
е	Benefits paid (including direct rollove	rs)	<u> 2e</u>					
f	Corrective distributions (see instruction	ons)	2f					* *
g	Certain deemed distributions of partic	cipant loans				ľ		, <u>V</u>
	(see instructions)		2g					
h	Administrative service providers (sala	aries, fees, and commissions)	2h					
i	Other expenses		2i			60		
j	Total expenses (add lines 2e, 2f, 2g,	2h and 2i)	2j			L		60
k	Net income (loss) (subtract line 2j fro	m line 2d)	<u>2k</u>			L		43,543
	<u> </u>	ructions)	21					20,430
3	remaining in the plan as of the end of the	s at anytime during the plan year in any of the fo plan year. Allocate the value of the plan's intere of the specific exceptions described in the instruc-	st in a comm	ories, check "Y ingled trust cor	es" and en entaining the	ter the cum assets of n	ent value of an	y assets plan on a line-
					Yes	No	Amou	ınt
а	Partnership/joint venture interests			3a	_	x		
b	Employer real property			3b		x		
C	Real estate (other than employer real			30		х		
d	, , ,			30		х		

	Schedule I (Form 5500) 2010	Pag	e 2-		
			Yes	No	Amount
3f	Loans (other than to participants)	3f		х	
g	Tangible personal property	3g		х	
Flored I	F. L. Committee on Constitute				
Part I	Compliance Questions During the plan year:		Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period		162	I NO	Amount
a	described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year fallures until fully corrected. (See instructions and DQL'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	ļ	х	
C	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	
е	Was the plan covered by a fidelity bond?	4e	х	1	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?	4 g		x	s liele.
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?	4 j		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		
	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	4m		x	
n	2520.101-3.)				
£-	the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		1	
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	es 🛭	∏ No	Amoun	t:
					-
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identi	fy the (plan(s) t	o which a	ssets or liabilities were
	transferred. (See instructions.) 5b(1) Name of plan(s)	£1	o(2)	EIN(s)	5b(3) PN(s)
	and it comes as busided		-\ - /	(0)	
			-		

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

File With IRS Only

Par	t I Identification						
A	Name of filer, plan administrator, or plan sponsor (see instructions) ENDION MEDICAL SERVICES, PC	B			fylng number ntification num		ions).
	Number, street, and room or suite no. (If a P.O. box, see instructions.)		20-	1993	401		
	4201 N BUFFALO ROAD		Socia	l securit	y number (SS	N)	
	City or town, state and ZIP code						
	ORCHARD PARK NY 14127						
C	Plan name	١.	Plar numb			n year endi	
		<u> </u>			MM	DD	YYYY
			•		4.0	١	
1	ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHARING PLAN	0	-	1	12	31	2010
			1	!			
4		 	<u>. </u>				
,	1		1				
Par	Extension of Time to File Form 5500 or Form 5500-EZ (see	inst	ructic	ns)			
1	I request an extension of time until 10 / 17 / 2011 to file Form	5500	or Fo	rm 550	0-EZ.		
	The application is automatically approved to the date shown on line 1 (above) if normal due date of Form 5500 or 5500-EZ for which this extension is requested, a months after the normal due date.						
	You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ file	lad af	tor th	a dua i	data for the	nlane lietod	in C abovo
	Tou must attach a copy of this Form 5000 to each Form 5000 and 5000-E2 in	iou ai		s due (Jate IOI (IIG	pians nsteu	III C above.
Note.	A signature is not required if you are requesting an extension to file Form 5500 or	Form	5500	EZ.			
Par	Extension of Time to File Form 5330 (see instructions)			_			_
2	I request an extension of time until to file Form You may be approved for up to a six (6) month extension to file Form 5330, after the same of			due da	te of Form 5	330.	
a	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/ame State in detail why you need the extension	endm	ent da	te .	•	С	
						 	