Form 5500	Annual Return/Report of Employee Ben		OMB Nos. 12 12	10-0110 10-0089	
Department of the Treasury Internal Revenue Service	This form is required to be filed for employee benefit plans under and 4065 of the Employee Retirement Income Security Act of 197 sections 6047(e), and 6058(a) of the Internal Revenue Code (t	4 (ERISA) and	2010		
Department of Labor Employee Benefits Security Administration	<ul> <li>Complete all entries in accordance with the instructions to the Form 5500.</li> </ul>	_	2010		
Pension Benefit Guaranty Corporation			This Form is Open to Pu Inspection	blic	
Part I Annual Report Iden	tification Information				
For calendar plan year 2010 or fiscal	blan year beginning 01/01/2010 and	ending 12/31/20	010		
A This return/report is for:	a multiemployer plan; a multiple-employer	plan; or			
	X a single-employer plan; A DFE (specify)				
<b>B</b> This return/report is:	the first return/report; the final return/report	t;			
	an amended return/report; a short plan year ret	urn/report (less tha	than 12 months).		
<b>C</b> If the plan is a collectively bergeing	ed plan, check here.		_		
<b>D</b> Check box if filing under:	Form 5558;		the DFVC program;		
	special extension (enter description)				
Part II Basic Plan Inform	nation—enter all requested information				
<b>1a</b> Name of plan NIAGARA HOSPITALIST, PC 401(K)	PROFIT SHARING PLAN & TRUST		1b Three-digit plan number (PN) ▶	001	
			1c Effective date of pla 01/01/2006	an	
2a Plan sponsor's name and address (Address should include room or s NIAGARA HOSPITALIST, PC	s (employer, if for a single-employer plan) suite no.)		2b Employer Identifica Number (EIN) 20-1993782	tion	
			<b>2c</b> Sponsor's telephon number 716-828-2434	e	
4201 N. BUFFALO ROAD ORCHARD PARK, NY 14127	4201 N. BUFFALO ROAD ORCHARD PARK, NY 14127		2d Business code (see instructions) 621111		

### 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 electronic signature.	10/05/2011	JOHN A BRACH MD
HERE		Date	Enter name of individual signing as plan administrator
SIGN	Filed with authorized/valid electronic signature.	10/05/2011	JOHN A BRACH MD
HERE		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.

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	Plan administrator's name and address (if same as plan sponsor, enter "Same")		ministrator's EIN	
NI/	AGARA HOSPITALIST, PC	20-1993782		
	01 N. BUFFALO ROAD CHARD PARK, NY 14127	nu	ministrator's telephone mber 3-828-2434	
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 the plan number from the last return/report:	and	4b EIN	
а	Sponsor's name		<b>4c</b> PN	
5	Total number of participants at the beginning of the plan year	5	14	
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).			
а	Active participants	6a	15	
b	Retired or separated participants receiving benefits	6b	0	
c	Other retired or separated participants entitled to future benefits	6c		
d	Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>	6d	15	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	0	
f	Total. Add lines <b>6d</b> and <b>6e</b>	6f	15	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	6	
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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Form 5500 (2010)

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2G 2J 2K 3D 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	<b>9a</b> Plan funding arrangement (check all that apply)			<b>9b</b> Plan benefit arrangement (check all that apply)				ment (check all that apply)				
	(1)	X	Insurance		(1)	X	Insur	ance				
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code	section 412(e)(3) insurance contracts				
	(3)	X	Trust		(3)	Х	Trust					
	(4)		General assets of the sponsor		(4)		Gene	ral assets of the sponsor				
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)											
		a Pension Schedules						b General Schedules				
а	Pensio	n Scl	hedules	b	General	l Scl	hedule	6				
а	Pensio (1)	n Scl	hedules R (Retirement Plan Information)	b	General (1)	I Scl		s H (Financial Information)				
а		n Sci		b		I Scł		-				
а	(1)	n Scl	<ul> <li>R (Retirement Plan Information)</li> <li>MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan</li> </ul>	b	(1)	I Scl	1	H (Financial Information)				
a	(1)	n Scl	<ul><li>R (Retirement Plan Information)</li><li>MB (Multiemployer Defined Benefit Plan and Certain Money</li></ul>	b	(1) (2)	I Sci	_1	H (Financial Information)   (Financial Information – Small Plan)				
а	(1)	n Scl	<ul> <li>R (Retirement Plan Information)</li> <li>MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan</li> </ul>	b	(1) (2) (3)	I Sci	_1	<ul> <li>H (Financial Information)</li> <li>(Financial Information – Small Plan)</li> <li>A (Insurance Information)</li> </ul>				

SCHEDULE	Α	Insuranc	e Information	1			
(Form 5500	(Form 5500)			OM	IB No. 1210-0110		
Department of the Treas	Department of the Treasury Internal Revenue ServiceThis schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2010	
Department of Labo Employee Benefits Security Ad		File as an at	tachment to Form 550	00.			
Pension Benefit Guaranty Co	prporation	<ul> <li>Insurance companies ar pursuant to El</li> </ul>	re required to provide th RISA section 103(a)(2).		on		m is Open to Public Inspection
For calendar plan year 20	10 or fiscal plan	year beginning 01/01/2010		and en	ding 12	2/31/2010	
A Name of plan NIAGARA HOSPITALIST	", PC 401(K)/PR	OFIT SHARING PLAN & TRUST		B Three plan	e-digit number (P	N) 🕨	001
C Plan sponsor's name a NIAGARA HOSPITALIST		e 2a of Form 5500.		D Employ 20-199	•	cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca NATIONWIDE LIFE INSU							
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	<ul> <li>(e) Approximate null persons covered at</li> </ul>			Policy or co	ontract year
(5) EIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To
31-4156830	66869	0000NIAG00NY00K	;	3	12/01/20	010	12/31/2010
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	l commissions paid. Lis	st in item 3	the agents	, brokers, and o	other persons in
	amount of comn	nissions paid		<b>(b)</b> To	tal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all p	ersons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commissi	ons or fees	s were paid	
							1
(b) Amount of sales ar			s and other commission				
commissions paid		(c) Amount	(1	<b>d)</b> Purpose	)	(e) Organization	
	I						
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commissi	ons or fees	s were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notic	chedule A (Form 5500) 2010		
	v.092308.1		

Page **2-**

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

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

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	

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

(b) Amount of sales and base		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Norma and address of the second business as other second to where a second size of the second side					

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

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

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

-

Page **3** 

Part II						
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	icts with each carrier ma	ay be treated as a un	it for purposes of
4	Curr	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 e				90861
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates  NOT PROVIDED BY INSURANCE CC	).			
	_					44507
	b	Premiums paid to carrier			6b	44597
	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 con retention of the contract or policy, enter amount			6d	1784
		Specify nature of costs CONTRACT COMMISSIONS			···· <u>1</u>	
	е	Type of contract: (1) Tindividual policies (2) group deferred	d annuitv			
	-	(3) ☐ other (specify) ►	,			
	2	. We are the set of the set of the set of the set of the distribution is the set of the		N		
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts ma		• •		
	а			tion guarantee		
		(3) guaranteed investment (4) other ►				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		<ul><li>(3) Interest credited during the year</li></ul>				
		(4) Transiened from separate account	7c(5)			
		(6)Total additions				
	d	Total of balance and additions (add <b>b</b> and <b>c(6)</b> ).				
		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	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions				
	f	Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )				

Schedule A (Form 5500) 2010

|--|

Pa	art II						
		If more than one contract covers the same gr information may be combined for reporting pu					
		the entire group of such individual contracts					
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	ployment	<b>h</b> Prescription drug
	iΓ	Stop loss (large deductible)	i HMO contract	, o∟ k			I Indemnity contract
	m			•			
	m	Other (specify)					
9	Expe	rience-rated contracts:					
-		Premiums: (1) Amount received		9a(1)			1
		(2) Increase (decrease) in amount due but unpaid	ł	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					_
		(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)		1	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement		
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
		Dividends or retroactive rate refunds due. (Do ne	ot include amount entered	d in <b>c(2)</b> .)		. 9e	
10	No	nexperience-rated contracts:				<b></b>	
	-	Total premiums or subscription charges paid to c				. 10a	
	b	If the carrier, service, or other organization incurr				104	
		retention of the contract or policy, other than repo	orted in Part I, item 2 abov	ve, report am	ount	. 10b	

Specify 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 Financial Info				ation—Sr	nall	OMB No. 1210-0110					
(Form 5500)					man	i iuii	-				
	Department of the Treasury Internal Revenue Service	to be filed under section 104 of the Employee Act of 1974 (ERISA), and section 6058(a) of the					2010				
	Department of Labor Employee Benefits Security Administration			e Code (the Cod	,		-	Thia	Form in Onon to D	while	
	Pension Benefit Guaranty Corporation	- File as a	an attac	hment to Form	5500.			ins	Form is Open to P Inspection	UDIIC	
For	calendar plan year 2010 or fiscal p	lan year beginning 01/01/20	10		a	and ending	12/3	31/2010	-		
	Name of plan GARA HOSPITALIST, PC 401(K)/P	ROFIT SHARING PLAN & TRUS	ЯΤ			Three-digit plan numb		•	001		
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 NIAGARA HOSPITALIST, PC						mployer Id -1993782	lentificatio	n Numbe	r (EIN)		
	nplete Schedule I if the plan covered all plan under the 80-120 participant							ete Scheo	dule I if you are filing	as a	
Pa	rt I Small Plan Financial	Information									
ass ber	bort below the current value of asse ets held in more than one trust. Do befit at a future date. Include all inco urance carriers. <b>Round off amount</b>	not enter the value of the portion me and expenses of the plan inc	of an in	surance contrac	t that g	uarantees	during th	is plan ye	ar to pay a specific	dollar	
1	Plan Assets and Liabilities:			<b>(a)</b> Be	ginning	g of Year		(b) End of Year			
а	Total plan assets		. 1a		316074					402427	
b	Total plan liabilities		. 1b		0					0	
С	Net plan assets (subtract line 1b f	rom line 1a)	<b>1c</b> 316074				316074			402427	
2 Income, Expenses, and Transfers for this Plan Year:			(	<b>a)</b> Amo	ount			<b>(b)</b> Total			
а	Contributions received or receivable	ble:									
	(1) Employers		2a(1)				15302				
	(2) Participants		2a(2)				70129				
	(3) Others (including rollovers)		2a(3)	<b>b</b> 0							
b	Noncash contributions		2b					-			
С	Other income		2c								
d	Total income (add lines 2a(1), 2a(	2), 2a(3), 2b, and 2c)	2d	2d					120176		
е	Benefits paid (including direct rollo	overs)	2e				0				
f	Corrective distributions (see instru						0				
g	Certain deemed distributions of pa (see instructions)		20				0				
h	· · · · · · · · · · · · · · · · · · ·				0						
i	Other expenses	,			2070						
÷	Total expenses (add lines 2e, 2f, 2				2070					2070	
J k	Net income (loss) (subtract line 2j	<b>O</b> . , ,								118106	
ī	Transfers to (from) the plan (see i	,	21							-31753	
3	Specific Assets: If the plan held a remaining in the plan as of the end c by-line basis unless the trust meets of	ssets at anytime during the plan yea f the plan year. Allocate the value o	ar in any f the plai	n's interest in a co							
	,					Yes	No		Amount		
а	Partnership/joint venture interests				3a		Х				
b	Employer real property				3b		Х				
С	Real estate (other than employer	real property)			3c		Х				
d	Employer securities				3d		X				
е	Participant loans		······		3e		Х				
For	Paperwork Reduction Act Notice	and OMB Control Numbers, s	ee the i	nstructions for	Form	5500			Schedule I (Form	5500) 201	

chedule I	(Form	5500)	2010
		v.0923	808.1

Schedule I (F	<sup>-</sup> orm 5500)	2010
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			Yes	No	Amount
3f	Loans (other than to participants)	3f		Х	
g	Tangible personal property	3g		Х	

P	art II Co	mpliance Questions				
4	During the	plan year:		Yes	No	Amount
а	described in	failure to transmit to the plan any participant contributions within the time period 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b	year or class	ans by the plan or fixed income obligations due the plan in default as of the close of plan ified during the year as uncollectible? Disregard participant loans secured by the account balance	4b		X	
С		ases to which the plan was a party in default or classified during the year as ?	4c		X	
d		any nonexempt transactions with any party-in-interest? (Do not include transactions line 4a.)	4d		X	
е	Was the pla	n covered by a fidelity bond?	4e	Х		35000
f	•	have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by onesty?	4f		X	
g		hold any assets whose current value was neither readily determinable on an established et by an independent third party appraiser?	4g		X	
h		receive any noncash contributions whose value was neither readily determinable on an market nor set by an independent third party appraiser?	4h		X	
i	•	at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel e, or partnership/joint venture interest?	4i		X	
j		plan assets either distributed to participants or beneficiaries, transferred to another plan, nder the control of the PBGC?	4j		X	
k	accountant (	ning a waiver of the annual examination and report of an independent qualified public QPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 See instructions on waiver eligibility and conditions.)	4k	х		
Т		failed to provide any benefit when due under the plan?	41		Х	
m		ndividual account plan, was there a blackout period? (See instructions and 29 CFR	4m		Х	
n		swered "Yes," check the "Yes" box if you either provided the required notice or one of ns to providing the notice applied under 29 CFR 2520.101-3	4n			
5a		ution to terminate the plan been adopted during the plan year or any prior plan year? ter the amount of any plan assets that reverted to the employer this year	Ye	s 🗙 N	lo /	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)

#### 5500 Electronic Filing Authorization

Plan Name:Niagara Hospitalist, PC 401(k)/Profit Sharing Plan & TrustEIN/PN:20-1993782/001Plan 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 Administrator (sign)

Plan Spon (sign)

(date)

	Form 5500	Annual Return/Repo	rt of Employe	e Benefit Plan	OMB N	los. 1210-0110 1210-0089			
	partment of the Treasury ternal Revenue Service								
	Department of Labor ployee Benefits Security Administration	•	ntries in accordance lons to the Form 550		2010				
Pension	Benefit Guaranty Corporation				This Form is Open t Inspection	o Public			
Par	t   Annual Report	Identification Information							
For th	e calendar plan year 201	0 or fiscal plan year beginning 01	/01/2010	and ending 12/3	1/2010				
A Th	is return/report is for:	a mulliemployer plan; X a single-employer plan;		a multiple-employer a DFE (specify)	plan; or				
B Th	is return/report is:	the first return/report; an amended return/report;		the final retum/repor	t; um/report (less than 12 n	nonths).			
C If t	he plan is a collectively-barg	jained plan, check here 🔒 🔒 🔒		• • • • • • • • • •		▶∐			
D Ch	eck box if filing under:	Form 5558; special extension (enter descripti	on)	automatic extension	the DFVC p	orogram;			
Par	t II Basic Plan Info	rmation enter all requested in	nformation.	··· ··· ··· ···	· · · · · · · · · · · · · · · · · · ·	·			
	Name of plan	t, PC 401(k)/Profit Sharir		:	1b Three-digit plan number (PN) ►	001			
					1c Effective date of pl 01/01/2006	an			
	Plan sponsor's name and a (Address should include roo	ddress (employer, if for a single-emplo om or suite no.)	yer plan)		2b Employer Identifica Number (EIN)	ntion			
:	Niagara Hospitalis	t, PC			20-1993782 2C Sponsor's telephor number (716) 828-242				
	4201 N. Buffalo Road 2d Business code (see instructions) US Orchard Park NY 14127 621111								
Cautio	on: A penalty for the late o	r incomplete filing of this return/rep	ort will be assessed	unless reasonable cause is	s established.				
Under statem	penalties of perjury and oth ents and attachments, as w	er penalties set forth in the instructions well as the electronic version of this retu	s, I declare that I have urn/report, and to the	e examined this return/report, best of my knowledge and be	including accompanying elief, it is true, correct, and	schedules, d complete.			
SIG HEF	RE/	15)	10.5.11	John A. Brach, MD					
	Signature of Blan ad	iministrator	Date	Enter name of individual si	gning as plan administrat	or			
SIG HEF		1 //b /	10.5.11	John A. Brach, MD					
	Signature of employ	er/plan sponsor	Date	Enter name of individual si	gning as employer or pla	n sponsor			
SIG HEF									

 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.
 Enter name of individual signing as DFE

Form 5500 (2010) v.092307.1

3a	Plan administrator's name and address (if same as plan sponsor, enter "Same	me")		31	b Administrator's EIN
	Same			30	C Administrator's telephone number
	If the name and/or EIN of the plan sponsor has changed since the last retur the plan number from the last return/report:	n/report filed	d fo	r this plan, enter the name, EIN an	nd 4b EIN
а	Sponsor's name				4c PN
5	Total number of participants at the beginning of the plan year		•	5	5 14
6	Number of participants as of the end of the plan year (welfare plans comple	te only lines	6a,	6b, 6c and 6d)	 I
a	Active participants		•	6	a 15
b	Retired or separated participants receiving benefits		•	6	ь
C	Other retired or separated participants entitled to future benefits		•	6	c
d	Subtotal. Add lines 6a, 6b and 6c		•	6	d 15
e	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive bene	fits	6	e 0
f	Total. Add lines 6d and 6e		•	6	f 15
g	Number of participants with account balances as of the end of the plan year complete this item)	r (only define			g 6
h	Number of participants that terminated employment during the plan year wit 100% vested				h o
7	Enter the total number of employers obligated to contribute to the plan (only				7
8a	If the plan provides pension benefits, enter the applicable pension feature	codes from	the	List of Plan Characteristic Codes i	in the instructions:
	2E 2G 2J 2K 3D 3H				
b	If the plan provides welfare benefils, enter the applicable welfare feature co	odes from th	ie L	ist of Plan Characteristic Codes in	the instructions:
9a	Plan funding arrangement (check all that apply)	9b Plan	be	nefit arrangement (check all that a	oply)
	(1) X Insurance			Insurance	
	(2) Code section 412(e)(3) insurance contracts	(2)	Ц	Code section 412(e)(3) insurance	e contracts
	(3) x Trust		X	Trust	
	(4) General assets of the sponsor	(4)	Ц	General assets of the sponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are		nd,	where indicated, enter the numbe	er attached. (See instructions
a	Pension Schedules		era	I Schedules	
	(1) R (Retirement Plan Information)	(1)	Н	H (Financial Informatio	•
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	M	I (Financial Information	•
	Purchase Plan Actuarial Information) - signed by the plan	(3)	鬥	<u>1</u> A (Insurance Information	•
	actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial	(4) (5)	Н	C (Service Provider Inf D (DFE/Participating P	

Form 5500 (2010)

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## **Sponsor Location Information**

Sponsor name: Niagara Hospitalist, PC Sponsor DBA name: Sponsor care of name:

4201 N. Buffalo Road

US Orchard Park NY 14127

SCHEDULE A (Form 5500)	Insura	nce Information	I	0	MB No. 1210-0110		
Department of the Treasury Internal Revenue Service		ired to be filed under sections come Security Act of 1974 (El	2010				
Department of Labor Employee Benefits Security Administration							
Pension Benefit Guaranty Corporation	nation	This F	form is Open to Public Inspection.				
For calendar plan year 2010 or fisca	l plan year beginning 01/01/20			1/2010			
A Name of plan			ee-digit n number (PN)	►	001		
Niagara Hospitalist, PC 40	)1(k)/Profit Sharing Plan	& Trust					
C Plan sponsor's name as shown	on line 2a of Form 5500.	D Em	ployer Indentificat	ion Number	(EIN)		
Niagara Hospitalist, PC			20-199	3782			
a separate Schedule     on a separate Schedule     Coverage Information:     (a) Name of insurance carrier     NATIONWIDE LIFE INSURANCE	A. Individual contracts grouped as a	unit in Pans II and III can be	reported on a sing		A		
(c) NAIC	(d) Contract or	(e) Approximate number			Policy or contract year		
(b) EIN code	identification number	persons covered at end policy or contract yea	1 (1) (1) (1)	rom	( <b>g</b> ) To		
31-4156830 66869	0000NIAG00NY00K	3	12/1/2	2010	12/31/2010		
2 Insurance fee and commission i descending order of the amount	nformation. Enter the total fees and t paid.	otal commissions paid. List ir	i item 3 the agents	s, brokers, ar	nd other persons in		
(a) Total amount o	f commissions paid	(b	Total amount of I	lees paid			
3 Persons receiving commissions	and fees. (Complete as many entrie	s as needed to report all pers	ons).				
(a) Nam	e and address of the agent, broker, o	or other person to whom com	missions or fees v	vere paid			
			•••••••••••••••••••••••••••••••••••••••				

(b) Amount of sales and base	Fees a	nd olher commissions paid	
commissions paid	(C) Amount	(d) Purpose	(e) Organization code
(a) Name ar	nd address of the agent, broker, or o	other person to whom commissions or fees we	ere paid

(b) Amount of sales and base	F			
commissions paid	(C) Amount	(d) Purpose		(e) Organization code
]	:			
For Paperwork Reduction Act Notic	e and OMB Control Numbers,	see the Instructions for Form 5500.	Sched	ule A (Form 5500) 2010 v.092308.1

Schedule A (Form 5500) 2010

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

(b) Amount of sales and base	Fee		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Name	and address of the agent, broker	or other person to whom commissions or fees were paid	

 (b) Amount of sales and base
 Fees and other commissions paid

 commissions paid
 (c) Amount
 (d) Purpose
 (e) Organization code

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

(b) Amount of sales and base	Fees a	nd other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
····			

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

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
			1

(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	(d) Purpose	(e) Organization code
·····			<u></u>

Page 2-

Pa	rt II Investment and Annuity Contract Information				
	Where individual contracts are provided, the entire group of such in this report.	dividual con	tracts with each carrier m	ay be treate	d as a unit for purposes of
4	Current value of plan's interest under this contract in the general account at ye	ear end		4	0
5	Current value of plan's interest under this contract in separate accounts at year	rend .		5	90,861
6	Contracts With Allocated Funds: a State the basis of premium rates NOT PROVIDED BY INSURANCE CO.				
	b Premiums paid to carrier			6b	44,597
	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 c or retention of the contract or policy, enter amount	connection v	ith the acquisition	6d	1,784
	Specify nature of costs				
	CONTRACT COMMISSIONS				
	e Type of contract (1) x individual policies (2) group deferred a	annuity			
	(3) other (specify)				
	If contract purchased, in whole or in part, to distribute benefits from a term			▶ []	
1	Contracts With Unallocated Funds (Do not include portions of these contracts				
а		immediate	participation guarantee		
	(3) guaranteed investment (4)	other 🕨			
h	Balance at the end of the previous year			7b	
	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) Olher (specify below)	7c(5)			
		10(0)	· · · · · · · · · · · · · · · · · · ·	·	
	•				
			an an an an an thu		l
	(6) Total additions			7c(6)	
	Total of balance and additions (add b and c(6))		· · · · · · · · ·	7d	
e	Deductions:		1999 - 1999 -		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	<u>7e(1)</u>			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			and a second
	(4) Other (specify below)	<u>7e(4)</u>	L		
	•				
	(5) Total deductions			7e(5)	
f	Balance at the end of the current year (subtracte(5) from d).	<u> </u>	• • • • • • • •	7f	

	Schedule A (Form 5500) 2010 Page 4		
Pa	rt III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of t information may be combined for reporting purposes if such contracts are experience-rated as a unit. We the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this	ere contracts	
8	Benefit and contract type (check all applicable boxes)         a ☐ Health (other than dental or vision)       b ☐ Dental       C ☐ Vision         e ☐ Temporary disability (accident and sickness)       f ☐ Long-term disability       g ☐ Supplemental unem         i ☐ Stop loss (large deductible)       j ☐ HMO contract       k ☐ PPO contract         m ☐ Other (specify) ►		d 🗌 Life insurance h 🗌 Prescription drug I 🗍 Indemnity contract
9 a	Experience-rated contracts         Premiums: (1) Amount received         (2) Increase (decrease) in amount due but unpaid         (3) Increase (decrease) in unearned premium reserve         (4) Earned ((1) + (2) - (3))	9a(4)	
b		9b(3) 9b(4)	
C	Remainder of premium: (1) Retention charges (on an accrual basis)       9c(1)(A)         (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)(C)         (H) Total retention       9c(1)(C)	9c(1)(H) 9c(2)	
d e	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement       .         (2) Claim reserves       .       .       .         (3) Other reserves       .       .       .	9d(1) 9d(2) 9c(3) 9e	
 10 a b	Nonexperience-rated contracts: Total premiums or subscription charges paid to carrier	10a	
	retention of the contract or policy, other than reported in Part I, item 2 above, report amount	10b	

Part IV Provision of Information				······································
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	• •	Yes	No	

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

	SCHEDULE I	Financial Information Small Plan OMB No. 1210-01						OMB No. 1210-0110
	(Form 5500) Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).						2010
E	Department of Labor mployee Benefits Security Administration		► File as an attachment to Form 5500.					s Form is Open to Public
	Pension Benefit Guaranty Corporation							Inspection.
	calendar plan year 2010 or fiscal plan	year beginning 01/01/2010		and endin	¥	/31/2010	<u> </u>	
Α	Name of plan		_		1	nree-digil		
	Niagara Hospitalist, PC 4	01(k)/Profit Sharing Plan & 9	Frust		pi	an number		001
					1		•	· ·
						<u>.</u>	·	
C	Plan sponsor's name as shown on lin	e 2a of Form 5500						n Number (EIN)
	Niagara Hospitalist, PC		• • • •			)-199378	_	
Comp	lete Schedule I if the plan covered few plan under the 80-120 participant rule	ver than 100 participants as of the beginning (see instructions). Complete Schedule H if	g of the pla reporting a	n year. You n	nay also	complete S	chedule	I if you are filing as a
-	Int I Small Plan Financial		reporting a	s a large plan		•		
			<u> </u>					<u>.</u>
assets benefi insura	beld in more than one trust. Do not e t at a future date. Include all income a nce carriers. Round off amounts to t	d liabilities, income, expenses, transfers an nter the value of the portion of an insurance and expenses of the plan including any trus he nearest dollar.	e contract t	hat guarantee rately mainta	es during ined fun	this plan ye d(s) and any	ear to pa y payme	ay a specific dollar ents/receipts to/from
1	Plan Assets and Liabilities:	ļ		(a) Beginni	ing of Ye	ear	(b) l	End of Year
a	Total plan assets		<u>1a</u>			316,074		402,427
b	•		<u>1b</u>			0		
<u>C</u>	Net plan assets (subtract line 1b from		<u>1c</u>			316,074		402,427
2	Income, Expenses, and Transfe	ers for this Plan Year:		(a) Amo	ount		(	b) Total
а	Contributions received or receivable							
	(1) Employers		2a(1)			15,302	.* ÷	
	(2) Participants		2a(2)			70,129		
	(3) Others (including rollovers) .		2a(3)			0		
b	Noncash contributions		<u>2b</u>	<u> </u>		0		
С	Other income		<u>2c</u>			34,745		
d	Total income (add lines 2a(1), 2a(2),	2a(3), 2b, and 2c)	2d					120,176
е	Benefits paid (including direct rollove	rs)	2e			0		
f	Corrective distributions (see instruction	ons)	2f			0		
g	Certain deemed distributions of partie	cipant loans						
	(see instructions)		_2g			0	÷.,	
h	Administrative service providers (sala	aries, fees, and commissions)	2h			0		
i	Other expenses	[	2i	2,070				
j	Total expenses (add lines 2e, 2f, 2g,	2h and 2i)	2j				2,070	
k	Net income (loss) (subtract line 2j fro	m line 2d)	2k				118,106	
	Transfers to (from) the plan (see inst	ructions)	21					(31,753)
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 If the specific exceptions described in the instruc	st in a comm					e of any assets
					Yes	No		Amount
а	Partnership/joint venture interests			3a		x		
b	Employer real property			3t	2	x		
C	Real estate (other than employer real	I property)		30	:	x		
d	Employer securities			30	i	x		
e	Participant loans			36	•	x		

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

Schedule I (Form 5500) 2010 v.092308

Schedule I (Form 5500) 2010

Page	2-	

			Yes	No	Amount
3f	Loans (other than to participants)	3f		X	· · · · · · · · · · · · · · · · · · ·
g	Tangible personal property	3g		X	
-					
Part I	I Compliance Questions				
4	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 participants' account balance	4b		x	
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		X	
е	Was the plan covered by a fidelity bond?	4e	X		35, 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		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 walver 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	-	
I	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	
п	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?			•	<u></u>
	If "Yes," enter the amount of any plan assets that reverted to the employer this year Y	es 🔰	No	Amoun	ıt:
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident transferred. (See instructions.)	ify the	plan(s) t	o which a	assets or liabilities were
	5b(1) Name of plan(s)	5	b(2)	EIN(s)	5b(3) PN(s)
		1			



# **Application for Extension of Time To File Certain Employee Plan Returns**

OMB No. 1545-0212

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

Part I	Identification

A	Name of filer, plan administrator, or plan sponsor (see instructions) Niagara Hospitalist, PC	B	<ul> <li>Filer's identifying number (see Instructions).</li> <li>Employer identification number (EIN).</li> </ul>						
	Number, street, and room or suite no. (If a P.O. box, see instructions.)		2	0-1	1993	782			
	4201 N. Buffalo Road			Social security number (SSN)					
	City or town, state and ZIP code								
	Orchard Park NY 14127								
C	Plan name			Plan			Plan year ending		
-			nur	nb	er	MM	DD	YYYY	
	1 <u>Niagara Hospitalist, PC 401(k)/Profit Sharing Plan &amp; T</u>	0		0	<u>1_</u>	12	31	2010	
:	2								
	3		l F						

I request an extension of time until 10 / 17 / 2011 \_\_\_\_ to file Form 5500 or Form 5500-EZ. 1

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 after the due date for the plans listed in C above.

Note. A signature is not required if you are requesting an extension to file Form 5500 or Form 5500-EZ.

Part III Extension of Time to File Form 5330 (see instructions)

2	I request an extension of time until to file Form 5330.						
	You may be approved for up to a six (6) month extension to file Form 5330, after the normal due date of Form 5330.						
a	Enter the Code section(s) imposing the tax						
b	Enter the payment amount attached						
с 3	For excise taxes under section 4980 or 4980F of the Code, enter the revision/amendment date						

ī authorized to prepare this application.