| 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 | Complete all entries in accordance with the instructions to the Form 5500. | _ | 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 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). | | |
| C If the plan is a collectively bergeing | ed plan, check here. | | _ | | |
| | | | | | |
| D Check box if filing under: | Form 5558; | | the DFVC program; | | |
| | special extension (enter description) | | | | |
| Part II Basic Plan Inform | nation—enter all requested information | | | | |
| 1a 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 | |
| | | | 2c 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.

Form 5500 (2010) v.092307.1

| | 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 | | 4c 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 6a , 6b , and 6c | 6d | 15 | |
| е | Deceased participants whose beneficiaries are receiving or are entitled to receive benefits | 6e | 0 | |
| f | Total. Add lines 6d and 6e | 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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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 | 9a Plan funding arrangement (check all that apply) | | | 9b 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 | R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan | b | (1) | I Scl | 1 | H (Financial Information) | | | | |
| a | (1) | n Scl | R (Retirement Plan Information)MB (Multiemployer Defined Benefit Plan and Certain Money | b | (1) (2) | I Sci | _1 | H (Financial Information) (Financial Information – Small Plan) | | | | |
| а | (1) | n Scl | R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan | b | (1) (2) (3) | I Sci | _1 | H (Financial Information) (Financial Information – Small Plan) A (Insurance Information) | | | | |

| 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 | Insurance companies ar pursuant to El | 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) EIN | (c) NAIC | (d) Contract or | (e) Approximate null persons covered at | | | Policy or co | ontract year |
| (5) EIN | code | identification number | policy or contract | | (f) | From | (g) 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) 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 | d) 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 |
| | | | |
| | | | |
| | | | |

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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 | | | | |
| | | (3) Interest credited during the year | | | | |
| | | (4) Transiened from separate account | 7c(5) | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | (6)Total additions | | | | |
| | d | Total of balance and additions (add b and c(6)). | | | | |
| | | 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 e(5) from d) | | | | |

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 Dental | С | Vision | | d Life insurance |
| | еĪ | Temporary disability (accident and sickness) | f Long-term disabili | ty g | Supplemental unem | ployment | h 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 c(2) .) | | . 9e | |
| 10 | No | nexperience-rated contracts: | | | | | |
| | - | 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 | | |
| C 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. Round off amount | 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: | | | (a) 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) | 1c 316074 | | | | 316074 | | | 402427 | |
| 2 Income, Expenses, and Transfers for this Plan Year: | | | (| a) Amo | ount | | | (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 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 | O . , , | | | | | | | | 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 | ⁻ orm 5500) | 2010 |
|---------------|------------------------|------|
|---------------|------------------------|------|

| | | | 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)

Page **2**_____

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 | (g) 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 - | | |
| | (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 | Filer's identifying number (see Instructions). Employer identification number (EIN). | | | | | | |
|---|--|---|---|------------------------------|-----------|-----|------------------|------|--|
| | 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 & 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.