Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury	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	1210-0089
Internal Revenue Service	sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).	2011
Employee Benefits Security Administration	Complete all entries in accordance with the instructions to the Form 5500.	
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection
	tification Information	
For calendar plan year 2011 or fiscal	plan year beginning 01/01/2011 and ending 12/31/	2011
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;	
	an amended return/report; a short plan year return/report (less t	han 12 months).
<b>C</b> If the plan is a collectively-bargain	ed plan, check here	▶∏
<b>D</b> Check box if filing under:	Form 5558; automatic extension;	the DFVC program;
	special extension (enter description)	
Part II Basic Plan Inform	nation—enter all requested information	
<b>1a</b> Name of plan ENDION MEDICAL SERVICES, PC 4	01(K)/PROFIT SHARING PLAN	1b Three-digit plan number (PN) ►
,		1c Effective date of plan 01/01/2007
2a Plan sponsor's name and addres ENDION MEDICAL SERVICES, PC	s, including room or suite number (Employer, if for single-employer plan)	<b>2b</b> Employer Identification Number (EIN) 20-1993401
		<b>2c</b> Sponsor's telephone number 585-344-7269
4201 N BUFFALO ROAD ORCHARD PARK, NY 14127	4201 N BUFFALO ROAD ORCHARD PARK, NY 14127	<b>2d</b> 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 HERE	Filed with authorized/valid electronic signature.	09/11/2012	JOHN A BRACH MD
-	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/11/2012	JOHN A BRACH MD
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

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	Plan administrator's name and address (if same as plan sponsor, enter "Same")		Iministrator's EIN
Εr	IDION MEDICAL SERVICES, PC		-1993401 ministrator's telephone
	01 N BUFFALO ROAD RCHARD PARK. NY 14127		ministrator s telephone
01			585-344-7269
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	2
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
_		0	
а	Active participants	6a	2
b	Retired or separated participants receiving benefits	6b	
_		6	
С	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	2
~		60	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e	6f	2
~			
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	2
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	<u> </u>
		-	1

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Page 2

**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	Plan fu	unding	arrangement (check all that apply)	9b	Plan ben	efit	arrangement (check all that apply)
	(1)	X	Insurance		(1)	X	Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)	X	Trust		(3)	X	Trust
	(4)		General assets of the sponsor		(4)		General assets of the sponsor
10	0 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						
а	Pensio	on <u>S</u> cl	nedules	b	General	Sc	chedules
	(1)		R (Retirement Plan Information)		(1)		H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	X	I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	Х	<u>1</u> A (Insurance Information)
			actuary		(4)		<b>C</b> (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)		<b>D</b> (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)

SCHEDULE (Form 5500		Insuran	ce Informatio	n		ОМ	IB No. 1210-0110
Department of the Treas Internal Revenue Serv		This schedule is required Employee Retirement Inc					2011
Department of Labo Employee Benefits Security Ad		<ul> <li>File as an attachment to Form 5500.</li> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>					
Pension Benefit Guaranty Co	prporation				ion	This Form is Open to Public Inspection	
For calendar plan year 20	11 or fiscal plar	year beginning 01/01/2011		and en	ding 12	2/31/2011	
A Name of plan ENDION MEDICAL SERV	/ICES, PC 401(	(K)/PROFIT SHARING PLAN			e-digit number (P	N) 🕨	001
C Plan sponsor's name a ENDION MEDICAL SERV		e 2a of Form 5500		D Emplo 20-199		cation Number (	(EIN)
		ing Insurance Contract ( Individual contracts grouped as a					
<b>1</b> Coverage Information:							
(a) Name of insurance ca NATIONWIDE LIFE INSU							
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
31-4156830	66869	0000ENDI00NY00K		2	01/01/20	)11	12/31/2011
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3.	the agents	, brokers, and c	other persons in
(a) Total a	amount of comr	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar			s and other commissio				
commissions pa	Id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid	
	<u>(., </u>						

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	and OMB Control Numbers,	see the instructions for Form 5500. Sche	edule A (Form 5500) 2011
			v.012611

### (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) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were paid		

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

 (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	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		

(b) Amount of sales and base commissions paid		(e) Organization	
	(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

Schedule A (Form 5500) 2011

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Ρ	art I	I Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with eac	ch carrier may be treated as a ur	it for purposes of
		this report.		
4		rent value of plan's interest under this contract in the general account at year end		0
5		rent value of plan's interest under this contract in separate accounts at year end		117482
6		tracts With Allocated Funds: State the basis of premium rates NOT PROVIDED BY INSURANCE COMPANY		
	а	State the basis of premium rates V NOT PROVIDED BY INSORANCE COMPANY		
	b	Premiums paid to carrier	6b	4690
	C	Premiums due but unpaid at the end of the year		4090
	d	If the carrier, service, or other organization incurred any specific costs in connection with the acquis	sition or	
	ŭ	retention of the contract or policy, enter amount		187
		Specify nature of costs CONTRACT COMMISSIONS		
	е	Type of contract: (1) X individual policies (2) group deferred annuity		
		(3) other (specify)		
	f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	▶□	
7		tracts With Unallocated Funds (Do not include portions of these contracts maintained in separate ac		
•	a	Type of contract: (1) $\prod$ deposit administration (2) $\prod$ immediate participation guarant		
	-	(3) ☐ guaranteed investment (4) ☐ other ►		
	b	Balance at the end of the previous year		
	C	Additions: (1) Contributions deposited during the year		
	-	(2) Dividends and credits		
		(3) Interest credited during the year		
		(4) Transferred from separate account		
		(5) Other (specify below)		
		•		
		(6)Total additions		
	d	Total of balance and additions (add <b>b</b> and <b>c(6)</b> ).	7d	
	е	Deductions:		
		(1) Disbursed from fund to pay benefits or purchase annuities during year <b>7e(1)</b>		
		(2) Administration charge made by carrier		
		(3) Transferred to separate account		
		(4) Other (specify below)		
		(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) 2011

Page 4	•
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Pa	rt II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu					
		the entire group of such individual contracts v					s cover individual employees,
8	Bene	efit and contract type (check all applicable boxes)	· ·				
	a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	v g	Supplemental unem	olovment	<b>h</b> Prescription drug
	. L	Stop loss (large deductible)	i HMO contract	, s_ k∏	PPO contract	bioymon	I Indemnity contract
	'			ĸ	PPO contract		
	m	Other (specify)					
9	- Lyne	riance roted contracto.					
9	•	rience-rated contracts: Premiums: (1) Amount received	Г	9a(1)			-
		(2) Increase (decrease) in amount due but unpaid		9a(1) 9a(2)			-
		(3) Increase (decrease) in unearned premium res		9a(3)			1
		(4) Earned ( <b>(1) + (2) - (3)</b> )				9a(4)	
	-	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			1
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			-
		(C) Other specific acquisition costs	-	9c(1)(C)			-
		(D) Other expenses	E	9c(1)(D)			4
		(E) Taxes		9c(1)(E)			-
		<ul><li>(F) Charges for risks or other contingencies</li><li>(G) Other retention charges</li></ul>	······	9C(1)(F)			-
		(H) Total retention	-			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_				
	Ч	Status of policyholder reserves at end of year: (1				\	
	d	(2) Claim reserves				9d(1) 9d(2)	
		(2) Claim reserves				9d(2) 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	-
10		nexperience-rated contracts:		···· •(=)./ ·····		1 00	
		Total premiums or subscription charges paid to c	arrier			10a	
	-	If the carrier, service, or other organization incurr					1
		retention of the contract or policy, other than repo				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	inswer to line 11 is "Yes," specify the information not provided.			

	SCHEDULE I	Einancial In	form	ation_Sr	nall	Dlan			OMB No. 1210-011	0
	SCHEDULE I Financial Information—Small Plan (Form 5500)									
	Department of the Treasury	o be file	b be filed under section 104 of the Employee <b>2011</b>							
	Internal Revenue Service	Internal Revenue Service Retirement Income Security Act of 1974 (ERISA), and s								
	Employee Benefits Security Administration	Department of Labor							Form is Open to	Public
	Pension Benefit Guaranty Corporation						4.0/0	4/0044	Inspection	
	calendar plan year 2011 or fiscal p	plan year beginning 01/01/201	1			nd ending		31/2011		
	Name of plan ION MEDICAL SERVICES, PC 40	1(K)/PROFIT SHARING PLAN				Three-digit		►	001	
					_					
	Plan sponsor's name as shown on ION MEDICAL SERVICES, PC	line 2a of Form 5500				mployer Id 1993401	entificatio	on Numbe	er (EIN)	
	mplete Schedule I if the plan covere all plan under the 80-120 participant							ete Scheo	dule I if you are filin	g as a
	art I Small Plan Financia									
ass ben	port below the current value of asse tets held in more than one trust. Do hefit at a future date. Include all inco urance carriers. <b>Round off amoun</b>	o not enter the value of the portion ome and expenses of the plan inc	of an ir	surance contrac	t that g	uarantees	during th	is plan ye	ar to pay a specific	c dollar
1	Plan Assets and Liabilities:			<b>(a)</b> Be	ginning	g of Year			(b) End of Year	
а	Total plan assets		. 1a			1	36943			134736
b	Total plan liabilities		. 1b							
С	Net plan assets (subtract line 1b	from line 1a)	_ 1c		136943			134736		
2	Income, Expenses, and Transfe	ers for this Plan Year:		(	( <b>a)</b> Amo	ount			<b>(b)</b> Total	
а	Contributions received or receiva	ble:								
	(1) Employers		. 2a(1)							
	(2) Participants		. 2a(2)				3752			
	(3) Others (including rollovers).		. 2a(3)							
b	Noncash contributions		. 2b							
С	Other income		. 2c				-5899			
d	Total income (add lines 2a(1), 2a	(2), 2a(3), 2b, and 2c)	. 2d							-2147
е	Benefits paid (including direct roll	lovers)	. 2e							
f	Corrective distributions (see instr	uctions)	. 2f							
g	Certain deemed distributions of p (see instructions)	articipant loans	. 2g							
h	Administrative service providers	(salaries, fees, and commissions)	. 2h							
i	Other expenses		. 2i				60			
j	Total expenses (add lines 2e, 2f,	2g, 2h, and 2i)	. 2j				_			60
k	Net income (loss) (subtract line 2	j from line 2d)	. 2k				_			-2207
Ι	Transfers to (from) the plan (see	instructions)	. <b>2</b> I							
3	remaining in the plan as of the end	assets at anytime during the plan yea of the plan year. Allocate the value o one of the specific exceptions descr	of the pla	n's interest in a co		ed trust co	ntaining th		of more than one pla	
				Γ		Yes	No		Amount	
а		5			3a		X			
b	Employer real property				3b		X			
С	Real estate (other than employer	real property)			3c		Х			
d	Employer securities				3d		Х			
е	-				3e		Х			
For	Paperwork Reduction Act Notic	e and OMB Control Numbers, s	ee the i	nstructions for	Form	5500			Schedule I (Form	5500) 2011

Schedule I (Form 5500) 2011 v.012611

			Yes	No	Amount
3f	Loans (other than to participants)	3f		Х	
g	Tangible personal property	3g		Х	

Pa	art II 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 plar year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.			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	Х		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 establishe market nor set by an independent third party appraiser?			X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parce of real estate, or partnership/joint venture interest?	4i		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan or brought under the control of the PBGC?	, 4j		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	×		
I	Has the plan failed to provide any benefit when due under the plan?	41		Х	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m	X		
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n	Х		
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	<b>Ye</b>	s XN	o Ar	nount:

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)

5b(2) EIN(s) 5b(3) PN(s)

## 5500 Electronic Filing Authorization

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

 EIN/PN:
 20-1993401/001

 Plan Year:
 01/01/2011 - 12/31/2011

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 Administfato (sign) 9-11-12 (date)

Plan Sponsor (sign) 9-11-12

(date)

Form 5500	Annual Return/Report of Employe This form is required to be filed for employee benefit pla		OMB Nos. 1210-0110 1210-0089	
Department of the Treasury Internal Revenue Service	2011			
Department of Labor Employee Benafits Security Administration	Complete all entries in accordance the instructions to the Form 550		2011	
Pension Benefit Guaranty Corporation			This Form is Open to Public Inspection	
	Identification Information			
For the calendar plan year 2011	1 or fiscal plan year beginning 01/01/2011	and ending 12/3	1/2011	
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; an amended return/report;	the final return/repor	t; um/report (less than 12 months).	
C If the plan is a collectively-barg	jained plan, check here	•••••••••••	· · · · <u>·</u> · · · · · ▶Ц	
D Check box if filing under:	X Form 5558;	automatic extension	; the DFVC program;	
	special extension (enter description)			
Part II Basic Plan Info	rmation enter all requested information.			
1a Name of plan	VICES, PC 401(K)/PROFIT SHARING PLAN		1b Three-digit plan number (PN) ► 001	
ENDION MEDICAL SERV	TLES, PC 401(R)/PROFIL SIMALING PLAN		1c Effective date of plan 01/01/2007	
2a Plan sponsor's name and a	jle-employer plan)	2b Employer Identification Number (EIN) 20-1993401		
ENDION MEDICAL SERV	/ICES, PC		2C Sponsor's telephone number (585) 344-7269	
4201 N BUFFALO ROAL	d		2d Business code (see instructions)	
US ORCHARD PARK	NY 14127		621111	
			s setablished	
Caution: A penalty for the late o	r incomplete filing of this return/report will be assessed er penalties set forth in the instructions. I declare that I have	uniess reasonable cause i	a eatabilatied.	
Under penaities of perjury and oth statements and attachments, as y	yell as the electronic version of this return/report, and to the l	best of my knowledge and b	elief, it is true, correct, and complete.	

SIGN HERE	OH MAS	9-11-12	JOHN A. BRACH, MD
11013	Signature of glan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		9-11-12	JOHN A. BRACH, MD
Libel.htm	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2011) v.012611

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	dministrator's telephone umber 4b EIN 4c PN 2
the plan number from the last return/report: Sponsor's name  Total number of participants at the beginning of the plan year	4c PN
the plan number from the last return/report: Sponsor's name  Total number of participants at the beginning of the plan year	4c PN
Total number of participants at the beginning of the plan year       5         Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).	
Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).	2
Active participants	
· · · · · · · · · · · · · · · · · · ·	2
Retired or separated participants receiving benefits	
Other retired or separated participants entitled to future benefits	
Subtotal. Add lines 6a, 6b, and 6c	2
Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	
Total. Add lines 6d and 6e	2
Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	2
Number of participants that terminated employment during the plan year with accrued benefits that were       6h	
Enter the total number of employers obligated to contribute to the plan (only multiemployer complete this item) 7	

9a	Plan funding arrangement (check all that apply)	9b	Plan benefit arrangement (check all that apply)				
	(1) X Insurance		(1)	x	Insurance		
	(2) Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts		
	(3) X Trust		(3)	x	Trust		
	(4) General assets of the sponsor		(4)		General assets of the sponsor		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attach	ed, and	l, wher	re ir	ndicated, enter the number attached. (See instructions)		
а	Pension Schedules	b General Schedules					
	(1) R (Retirement Plan Information)		(1)	U	H (Financial Information)		
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	R	I (Financial Information - Small Plan)		
	Purchase Plan Actuarial Information) - signed by the plan		(3)	M	<u>1</u> A (Insurance Information)		
	actuary		(4)	U	C (Service Provider Information)		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		(5)		D (DFE/Participating Plan Information)		
	Information) - signed by the plan actuary		(6)	11	G (Financial Transaction Schedules)		

# **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)						OMB No. 1210-0110			
Department of the Treasury Internal Revenue Service         This schedule is required to be filed under sections 104 of the Employee Retirement Income Security Act of 1974 (ERISA).							2011		
Department of Labor File as an attachment to Form 5500.									
Pension Benefit Guaranty Corporation Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).					This Form is Open to Publi Inspection.				
For calendar plan year 201	1 or fiscal pl	an year beginning 01/01/20	11	and ending	12/31	/2011			
A Name of plan				B Three-dig plan num		►	001		
ENDION MEDICAL SERV	ICES, PC	401(K)/PROFIT SHARING	PLAN		· .				
C Plan sponsor's name a	is shown on	line 2a of Form 5500.		D Employer Indentification Number (EIN)					
ENDION MEDICAL SERV	ICES, PC				20-199:	3401			
		ing Insurance Contract Co Individual contracts grouped as a					n for each contract		
1 Coverage Information:									
(a) Name of insurance carr	ier								
NATIONWIDE LIFE INS	URANCE CO	D.							
	(c) NAIC	(d) Contract or persons covere- identification number policy or contract				Policy or contract			
(b) EIN	code				( <b>f</b> ) Fro	m	( <b>g</b> ) To		
31-4156830	66869	0000END100NY00K		2	1/1/20:	11	12/31/2011		
2 Insurance fee and com descending order of th		rmation. Enter the total fees and to aid.	otal commissions pai	d. List in item	3 the agents,	brokers, and	other persons in		
(a) Total	amount of c	ommissions paid		(b) Tota	amount of fe	es paid			
		0				0			
3 Persons receiving corr	missions an	d fees. (Complete as many entries	s as needed to report	all persons).					
	(a) Name a	and address of the agent, broker, o	or other person to who	om commissio	ns or fees we	ere paid			

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

Fees and other commissions paid (b) Amount of sales and base (d) Purpose (e) Organization code (C) Amount commissions paid Schedule A (Form 5500) 2011

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

v.012611

## (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		
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 wer	e paid

(b) Amount of sales and base			
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			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	<u></u> ==		

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

(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

Schedule A (Form 5500) 2011

Pai	t II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such ind	ividual contract	s with each carri	ier may be treated	as a unit for purposes of
	this report.				
	Current value of plan's interest under this contract in the general account at year		• • • • •		0
	Current value of plan's interest under this contract in separate accounts at year	end	• • • • •	5	117,482
6 a	Contracts With Allocated Funds: State the basis of premium rates				
•	NOT PROVIDED BY INSURANCE COMPANY				
t	Premiums paid to carrier			· · 6b	4,690
C				· · 6c	
C	If the carrier, service, or other organization incurred any specific costs in co or retention of the contract or policy, enter amount	nnection with th	e acquisition	6d	187
	Specify nature of costs				
e	CONTRACT COMMISSIONS Type of contract (1) x individual policies (2) group deferred a (3) other (specify) ►	nnuity			
f	If contract purchased, in whole or in part, to distribute benefits from a termi	nating plan che	ck here	▶□	
7	Contracts With Unallocated Funds (Do not include portions of these contracts			s)	·
a	Type on contract (1) deposit administration (2)	immediate parti	cipation guarant	ee	
	(3) guaranteed investment (4)	other 🕨			
	Balance at the end of the previous year	7c(1)		<b>7</b> b	
U U	(2) Dividends and credits	7c(2)		·	4.1
	(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)	· · _ · · · · · · · · · · · · · · · · ·
h	Total of balance and additions (add b and c(6))			7d	
e	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)	<u>7e(4)</u>			
	▶		,80 g.C.		· · · · ·
		r K			
	(5) Total deductions			. 7e(5)	
f	Balance at the end of the current year (subtract e(5) from d).	<u></u> .	<u></u> .	. 7f	· · · · · · · · · · · · · · · · · · ·

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Part	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same e information may be combined for reporting purposes if such contracts are exp the entire group of such individual contracts with each carrier may be treated if	erience-rated as a unit. Where contra	
8 B a e i r	Temporary disability (accident and sickness)       f       Long-term disability         Stop loss (large deductible)       j       HMO contract	C Vision G Supplemental unemployment K PPO contract	d 🗌 Life insurance h 🗍 Prescription drug I 🗍 Indemnity contract
a P ((	cperience-rated contracts: remiums: (1) Amount received	9a(1) 9a(2) 9a(3)	
<b>b</b> в ((	I) Earned ((1) + (2) - (3))		3)
•	(A) Commissions.       (A) Commissions.         (B) Administrative service or other fees       (A) Commissions.         (C) Other specific acquisition costs       (A) Commissions.	9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D)	
ſ	<ul> <li>(E) Taxes</li></ul>	9c(1)(E)           9c(1)(F)           9c(1)(G)	
d s (	c) Dividends of retroactive rate returns. (The amounts where paid in cash, ratus of policyholder reserves at end of year: (1) Amount held to provide benefits a contractive rate returns.         c) Claim reserves		)
10 N ат b ır	onexperience-rated contracts: otal premiums or subscription charges paid to carrier		
	tention of the contract or policy, other than reported in Part I, item 2 above, report a iy nature of costs	amount	2

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	Fi	inancial Inform	ation S	mall Plan				0	MB No.	1210-0110	
	(Form 5500)		This schedule is required to be filed under section 104 of the Employee									
	Department of the Treasury Internal Revenue Service	Retirement Inco	Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).							2011		
Department of Labor Emptoyee Benefits Security Administration File as an attachment to Form 5500.								This Form is Open to Public Inspection.				
	Pension Benefit Guaranty Corporation	I									cuun.	
_	calendar plan year 2011 or fiscal plan	year beginning	01/01/2011		and ending	_		/2011	,	1		
	Name of plan				1		Three	-	-			
	ENDION MEDICAL SERVICES,	PC 401 (K) / PROB	FIT SHARING PL	AN	ŀ		plan r	umber (	(PN) 🕨	1	001	
					1							
						<b>n</b>						
	Plan sponsor's name as shown on lin				{		•	•	ntification	Number	(EIN)	
	ENDION MEDICAL SERVICES,							99340				
	lete Schedule I if the plan covered fev							nplete S	Schedule I	if you a	re filing as a	
`	plan under the 80-120 participant rule		omplete Schedule H	ir reporting a	s a large plan (	or DF	·E.					
Pa	rt I Small Plan Financial	Information										
Repor	t below the current value of assets an	d liabilities, income, e	expenses, transfers	and changes	in net assets d	luring	j the p	lan yea	r. Combin	ie the va	alue of plan	
assets	held in more than one trust. Do not e	inter the value of the	portion of an insural	nce contract t	hat guarantees	s duri	ng thi	s plan y	ear to pay	a speci	fic dollar	
	t at a future date. Include all income a nce carriers. Round off amounts to t		plan including any tr	usi(s) or sepa	irately maintair	nea n	una(s	i and an	iy paymen	ts/receit	ots to/mom	
	ince camers: Round on amounts to t			- <u>1</u> .								
1	Plan Assets and Liabilities:				(a) Beginnin	ng of '			(b) Er	d of Ye		
а	Total plan assets	• • • • • •		<u>1a</u>			130	5,943			134,736	
b				1b								
C	Net plan assets (subtract line 1b from	n line 1a)	<u></u>	<u> </u>	136,943						134,736	
2	Income, Expenses, and Transfe	ers for this Plan Y	ear:		(a) Amou	unt			<u>(b</u>	) Total		
а	Contributions received or receivable					11 A.				••		
	(1) Employers			2a(1)								
	(2) Participants			2a(2)				3,752				
	(3) Others (including rollovers) .			2a(3)								
b	Noncash contributions			2b								
С	Other income			. <u>2</u> c			(5,	899)				
d	Total income (add lines 2a(1), 2a(2),	, 2a(3), 2b, and 2c)	<b></b> .	. 2d						_	(2,147)	
e	Benefits paid (including direct rollove		• • • • • • •	. 2e						1.1		
f	Corrective distributions (see instructi			. 2f						1. 1. 1. 1. 1. 1.		
g	Certain deemed distributions of parti											
3	(see instructions)	•		. 2g								
h	Administrative service providers (sal		missions)	. 2h								
i	Other expenses	· · · · · · ·		. <u>2i</u>				60				
i	Total expenses (add lines 2e, 2f, 2g,	, 2h, and 2i)		. <u>2j</u>							60	
k	Net income (loss) (subtract line 2) fro				]						(2,207)	
Ĩ	Transfers to (from) the plan (see inst			01	1						_	
3	Specific Assets: If the plan held asse	ts at anytime during the	olan year in any of the	e following cate	gories, check "Y	'es" ar	nd ent	er the cur	rrent value	of any as	sets	
	remaining in the plan as of the end of the	e plan year. Allocate the	value of the plan's interplane	erest in a comn	ningled trust con	ntainin	g the a	assets of	more than	one plan	on a line-	
	by-line basis unless the trust meets one	of the specific exception	ns described in the inst	ructions.								
						Y	'es	No	A	mount		
9	Partnership/joint venture interests				<b>3</b> a	-		x	<u> </u>			
	r envicionity/joint rendue intercoro					<u> </u>						

		103	RO	Amount
a	Partnership/joint venture interests		x	
	Employer real property		x	
Ĉ	Real estate (other than employer real property)		X	
d	Employer securities		X	
	Participant loans		x	
	Paperwork Reduction Act Notice and OMB Control Numbers, see the Instructions for Form 5500.			Schedule I (Form 5500) 2011

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	_	Ye	s	No	Amount
3f	Loans (other than to participants)	B <b>f</b>		х	
g	Tangible personal property	g		x	
Part	Compliance Questions				<u>_</u>
4	During the plan year:	Ye	s	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected, (See instructions and DOL's Voluntary Fiduciary Correction Program)	a		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	lb		x	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	lc		x	· - · · · · · ·
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	ld		X	
е	Was the plan covered by a fidelity bond?	<u>le x</u>			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?	If		x	· · · · · · · · · · · · · · · · · · ·
9	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?	lg		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?	lh		<u>x</u>	
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/jcint venture interest?	Ji		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?	ij		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.)	lk X	:		
1	Has the plan failed to provide any benefit when due under the plan?	<u>     _</u>		<u>x</u>	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	lm x	<u> </u>	· ·	
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	ln X	:	•	
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?				
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	X N	• •	Amour	it:
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan( transferred. (See instructions.)				
	5b(1) Name of plan(s)	5b(2)	) E	EIN(s)	5b(3) PN(s)

 5D(1)
 SD(2)
 EIN(s)
 SD(3)
 PN(s)

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.

#### Lef. 41**6**1 .+:

Pa	Identification											
A	Name of filer, plan administrator, or plan sponsor (see instructions)	B Filer's identifying number (see instructions)										
••	ENDION MEDICAL SERVICES, PC		Employer identification number (EIN)									
	Number, street, and room or suite no. (If a P.O. box, see instructions)			20-1993401								
	4201 N BUFFALO ROAD		Social	security	y number (SSN)	(see instruction	ons)					
	City or town, state, and ZIP code		- · ·			••••	•					
	ORCHARD PARK NY 14127											
C			Plan		Pla	n year endi	ng					
	Plan name	MM	DD	ΥΥΥΥ								
			1									
	1 ENDION MEDICAL SERVICES, PC 401(K)/PROFIT SHARING PLAN	0	10	1	12	31	2011					
			1									
	2		1									
			1									
	3		1	1								
	The Enternation of Time To File Form FEOO Series and/or Form 905											
Pai	t II Extension of Time To File Form 5500 Series, and/or Form 895	19-33A										
1	I request an extension of time until10 / 15 / 2012 to file For	rm 5500 s	series (s	ee inst	ructions).							
•	Note. A signature IS NOT required if you are requesting an extension to file Form 55		•		,							
	Note: A signature to not required if you are requesting an extension to me round											
2	request an extension of time until to file Form 8955-SSA (see instructions).											
-	Note. A signature IS required if you are requesting an extension to file Form 8955-SSA.											
	Note: A signatore to requires in you are requeeding an excension to me rear ever	••••										
	The application Is automatically approved to the date shown on line 1 and/or line 2 the normal due date of Form 5500 series, and/or Form 8955-SSA for which this exter and/or line 2 (above) is not later than the 15th day of the third month after the normation of the series and the series are series are series are series and the series are series are series and the series are series are series are series are series are series and the series are series ar	ension is I	requeste	ie Form ed, and	n 5558 is filed I <b>(b)</b> the date o	on or before on line 1						
Par	t III Extension of Time To File Form 5330 (see instructions)											
3	I request an extension of time until to file For	rm 5330.										
_	You may be approved for up to a 6 month extension to file Form 5330, after the nom	nal due d	ate of F	orm 53	30.							
	• • • •											
а	Enter the Code section(s) imposing the tax	. ►	a									
b	Enter the payment amount attached	• • •		•••	• •	b						
C	For excise taxes under section 4980 or 4980F of the Code, enter the revision/amend	Iment dat	ie ·	•••	• ►							
4	State in detail why you need the extension:											
		<u>.</u>										

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.