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	blan 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 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).
C If the plan is a collectively-bargain	ed plan, check here	
D 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	
1a Name of plan NIAGARA HOSPITALIST, PC 401(K)	/PROFIT SHARING PLAN & TRUST	1b Three-digit plan number (PN) ►
		1c Effective date of plan 01/01/2006
2a Plan sponsor's name and addres NIAGARA HOSPITALIST, PC	s, including room or suite number (Employer, if for single-employer plan)	2b Employer Identification Number (EIN) 20-1993782
		2c Sponsor's telephone number 716-828-2434
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 HERE	Filed with authorized/valid electronic signature.	09/14/2012 Date	JOHN A BRACH MD Enter name of individual signing as plan administrator
		Duto	
SIGN HERE	Filed with authorized/valid electronic signature.	09/14/2012	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 -1993782
	AGARA HOSPITALIST, PC	-	ministrator's telephone
	01 N. BUFFALO ROAD RCHARD PARK, NY 14127		imber
			716-828-2434
			-
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	6
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	6
b	Retired or separated participants receiving benefits	6b	
c	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a, 6b, and 6c	6d	6
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e	6f	6
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	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
-		•	

Form 5500 (2011)

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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	Plan fu	unding	arrangement (check all that apply)	9b	Plan bene	əfit	arrangement (check all that apply)	
	(1)	X	Insurance		(1) X Insurance			
	(2)		Code section 412(e)(3) insurance contracts		(2)	(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	10 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	hedules	
	(1)	X	R (Retirement Plan Information)		(1)		H (Financial Information)	
	(2)	Π	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)		C (Service Provider Information)	
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)		D (DFE/Participating Plan Information)	
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)	

	•						
SCHEDULE		Insuranc	e Information	n		ON	IB No. 1210-0110
(Form 5500 Department of the Treas		This schedule is required	to be filed under section	on 104 of th	е		
Internal Revenue Serv	vice	Employee Retirement Inc					2011
Department of Labo Employee Benefits Security Ad		File as an at	ttachment to Form 55	600.			
Pension Benefit Guaranty Co	orporation	 Insurance companies an pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	11 or fiscal plan	year beginning 01/01/2011		and en	ding 12	2/31/2011	
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 Emplo 20-199		cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
NATIONWIDE LIFE INSU	JRANCE CO.						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
31-4156830	66869	0000NIAG00NY00K		3	12/01/20	011	12/31/2011
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	I commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	s were paid	
(b) Amount of sales ar			s and other commission				
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	s were paid	
	(a) Harris di						

(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.	Schedule A (Form 5500)	,
			v.01	12611

(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			
		Where individual contracts are provided, the entire group of such individual contracts with each carrier ma this report.	ly be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year end	4	
		ent value of plan's interest under this contract in separate accounts at year end		80314
6	Con	tracts With Allocated Funds:		
	а	State the basis of premium rates NOT PROVIDED BY INSURANCE CO.		
	_			
	b	Premiums paid to carrier	<u>6b</u>	5000
	C	Premiums due but unpaid at the end of the year	6c	
	d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	6d	80
		Specify nature of costs CONTRACT COMMISSIONS	··· <u>11</u>	
	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 accounts)		
'	a	Type of contract: (1) deposit administration (2) immediate participation guarantee		
	a			
		(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	7c(6)	
	d	Total of balance and additions (add b and c(6)).	7d	
	е	Deductions:		
		(1) Disbursed from fund to pay benefits or purchase annuities during year 7e(1)		
		(2) Administration charge made by carrier		
		(3) Transferred to separate account		
		(4) Other (specify below)		
		(5) Total deductions	7e(5)	
	f	Balance at the end of the current vear (subtract e(5) from d)		

Schedule A (Form 5500) 2011

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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 Dental	c	Vision		d Life insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	v g	Supplemental unem	olovment	h 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 ((1) + (2) - (3))				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)			-
		(F) Charges for risks or other contingencies(G) Other retention charges	······	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	Financial In	form	ation—Sr	nall	Plan			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						2011				
	Department of Labor Employee Benefits Security Administration			e Code (the Cod	- /		-	Thia				
·	Pension Benefit Guaranty Corporation	File as a	an attac	hment to Form	5500.			ins	Form is Open to I Inspection	JUDIIC		
For	calendar plan year 2011 or fiscal pl	an year beginning 01/01/201	11		а	nd ending	12/3	31/2011	-			
	Name of plan GARA HOSPITALIST, PC 401(K)/PF	ROFIT SHARING PLAN & TRUS	т			Three-digit		•	001			
	Plan sponsor's name as shown on li GARA HOSPITALIST, PC	ine 2a of Form 5500				mployer Id 1993782	entificatio	on Numbe	er (EIN)			
	nplete Schedule I if the plan covered all plan under the 80-120 participant r							ete Scheo	dule I if you are filing	as a		
Pa	art I Small Plan Financial	Information										
ass ben	bort below the current value of asset ets held in more than one trust. Do hefit at a future date. Include all inco urance carriers. Round off amounts	not enter the value of the portion me and expenses of the plan inc	of an ir	surance contrac	t that g	uarantees	during thi	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			4	02427			193986		
b	Total plan liabilities		. 1b				0			0		
С	Net plan assets (subtract line 1b fr	om line 1a)	1c			4	02427			193986		
2	Income, Expenses, and Transfe	rs for this Plan Year:		(a) Amo	ount			(b) Total			
а	Contributions received or receivab	le:										
	(1) Employers		2a(1)				0					
	(2) Participants		2a(2)				8877					
			. 2a(3)									
b	Noncash contributions		()									
c	Other income		2c				-5174					
d	Total income (add lines 2a(1), 2a(2		20 2d							3703		
_	Benefits paid (including direct rollo					2	10907					
e f						_						
t g	Corrective distributions (see instru Certain deemed distributions of pa		. 2f									
_	(see instructions)		. 2g									
h	Administrative service providers (s	alaries, fees, and commissions)	. 2h				1237					
i	Other expenses		. 2i									
j	Total expenses (add lines 2e, 2f, 2	g, 2h, and 2i)	. 2j	-			_			212144		
k	Net income (loss) (subtract line 2j	from line 2d)	. 2k	-			Ļ			-208441		
	Transfers to (from) the plan (see in											
3	Specific Assets: If the plan held as remaining in the plan as of the end of by-line basis unless the trust meets of	f the plan year. Allocate the value o	of the pla	n's interest in a co		ed trust co	ntaining th		of more than one plar			
				ſ		Yes	No		Amount			
а	Partnership/joint venture interests.				3a		X					
b	Employer real property				3b		X					
C	Real estate (other than employer r	eal property)			3c		X					
d	Employer securities				3d		X					
е	Participant loans				3e		X					
For	Paperwork Reduction Act Notice	and OMB Control Numbers, s	ee the i	instructions for	Form	5500		5	Schedule I (Form 5	500) 2011		

chedule	l (Form	5500)	201	1
		v.01	261	1

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

Pa	art II 🛛 🔾	Compliance Questions				
4	During	he plan year:		Yes	No	Amount
а	described	e a failure to transmit to the plan any participant contributions within the time period I in 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 cl	loans by the plan or fixed income obligations due the plan in default as of the close of plan assified during the year as uncollectible? Disregard participant loans secured by the t's account balance.	4b		X	
С	,	leases to which the plan was a party in default or classified during the year as ble?	4c		X	
d		re any nonexempt transactions with any party-in-interest? (Do not include transactions on line 4a.)	4d		X	
е	Was the p	blan covered by a fidelity bond?	4e	Х		35000
f		an have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by ishonesty?	4f		Х	
g	•	an hold any assets whose current value was neither readily determinable on an established or set by an independent third party appraiser?	4g		Х	
h		an receive any noncash contributions whose value was neither readily determinable on an ad market nor set by an independent third party appraiser?	4h		X	
i		an at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel tate, or partnership/joint venture interest?	4i		X	
j		he plan assets either distributed to participants or beneficiaries, transferred to another plan, t under the control of the PBGC?	4j		X	
k	accountar	aiming a waiver of the annual examination and report of an independent qualified public nt (IQPA) 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	X		
I	Has the p	lan failed to provide any benefit when due under the plan?	41		Х	
m		n individual account plan, was there a blackout period? (See instructions and 29 CFR -3.)	4m	X		
n		answered "Yes," check the "Yes" box if you either provided the required notice or one of tions to providing the notice applied under 29 CFR 2520.101-3	4n	Х		
5a		olution to terminate the plan been adopted during the plan year or any prior plan year? enter the amount of any plan assets that reverted to the employer this year	Ye	s 🗙 N	o A	mount:

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)

	SCHEDULE R Retirement Plan Information						10-0110					
	-	rm 5500) ent of the Treasury		is required to be file						201	1	
	Internal	Revenue Service		irement Income Secu 58(a) of the Internal F			section					
Employee Benefits Security Administration File as an attachment to Form 5500.						lic						
For		fit Guaranty Corporation an year 2011 or fiscal p	lan year beginning	01/01/2011		and en	ding	12/31/2	011			
AN	lame of pla			LAN & TRUST				e-digit n numbe I)	er •	(001	
		r's name as shown on li PITALIST, PC	ine 2a of Form 5500	1				loyer Ide)-199378		on Numb	er (EIN)	
Pa	rt I Di	stributions										
All	references	to distributions relate	only to payments	of benefits during t	he plan year.							
1		e of distributions paid in						_				
2		EIN(s) of payor(s) who p						1 r (if more	a than tu		EINs of th	e two
2		o paid the greatest dolla					iy ille yea			vo, enter		etwo
	EIN(s):	95-2834236		_								
	Profit-sha	aring plans, ESOPs, an	nd stock bonus pla	ns, skip line 3.			1		i			
3		f participants (living or d						3				
P		Funding Informati		ot subject to the mini	mum funding require	ements of	section o	f 412 of	the Inter	nal Reve	enue Code	or
4		administrator making an	/	section 412(d)(2) or E	RISA section 302(d)	(2)?			Yes	1	No	N/A
	If the plar	n is a defined benefit p	olan, go to line 8.							_	_	_
5	plan year,	r of the minimum funding see instructions and en	nter the date of the ru	uling letter granting the	he waiver. Date		י		У	Y	′ear	
•		npleted line 5, comple					Г	this sc	hedule.			
6		the minimum required co ency not waived)					-	6a				
		the amount contributed						6b				
		act the amount in line 6b										
		a minus sign to the left						6c				
_	•	npleted line 6c, skip li										
7	Will the m	inimum funding amount	t reported on line 6c	be met by the fundin	g deadline?				Yes	I	10	N/A
8	authority p	e in actuarial cost metho providing automatic appl ator agree with the chang	roval for the change	or a class ruling lette	er, does the plan sp	onsor or p	olan	Π	Yes	۱ П	1o	N/A
P		Amendments	J									
9		defined benefit pension	n plan, were any ame	endments adopted d	ring this plan							
U	year that i	ncreased or decreased check the "No" box	the value of benefits	s? If yes, check the a	ppropriate	Increa	se	Decre	ase	Both	י 🗌	No
Ра	rt IV	ESOPs (see instrustion skip this Part.	ructions). If this is no	t a plan described ur	nder Section 409(a)	or 4975(e)(7) of the	Interna	Revenu	ie Code,		
10	Were una	llocated employer secur	rities or proceeds fro	om the sale of unallo	cated securities used	d to repay	any exer	npt loan	?		Yes	No
11		the ESOP hold any pre									Yes	No
		ESOP has an outstand instructions for definitio	•							[Yes	No
12		ESOP hold any stock th	,								Yes	No
For	Paperwor	k Reduction Act Notice	e and OMB Control	I Numbers, see the	instructions for Fo	orm 5500.			Sche	dule R (F	orm 5500 v.0) 2011 12611

Pa	Part V Additional Information for Multiemployer Defined Benefit Pension Plans									
13			lowing information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in ee instructions. Complete as many entries as needed to report all applicable employers.							
	а	Name	of contributing employer							
	b	EIN	C Dollar amount contributed by employer							
	d	Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year								
	е	сотр	Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)							
		(1)	ase unit measure: Hourly Weekly Unit of production Other (specify):							
	а	Name	of contributing employer							
	b	EIN	C Dollar amount contributed by employer							
	d		ollective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box e instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year							
	e	<i>comp</i> (1)	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) contribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):							
	а	Name	of contributing employer							
	b	EIN	C Dollar amount contributed by employer							
	d		billective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box							
	e	<i>comp</i> (1)	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) contribution rate (in dollars and cents) ase unit measure: Hourly Weekly Unit of production Other (specify):							
	а	Name	of contributing employer							
	b	EIN	C Dollar amount contributed by employer							
	d		billective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box							
	e	<i>comp</i> (1)	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) Contribution rate (in dollars and cents) Case unit measure: Hourly Weekly Unit of production Other (specify):							
	а	Name	of contributing employer							
	b	EIN	C Dollar amount contributed by employer							
	d		ollective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box e instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year							
	e	Contribution rate information (<i>If more than one rate applies, check this box</i> and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).) (1) Contribution rate (in dollars and cents) (2) Base unit measure: Hourly Weekly Unit of production Other (specify):								
	а	Name	of contributing employer							
	b	EIN	C Dollar amount contributed by employer							
	d		billective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box e instructions regarding required attachment. Otherwise, enter the applicable date.) Month Day Year							
	e	Contr comp (1)	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items 13e(1) and 13e(2).) contribution rate (in dollars and cents)							

14	Enter the number of participants on whose behalf no co	ontributions were made by an	employer as an employer of the
----	--------------------------------------------------------	------------------------------	--------------------------------

	participant for:		
	a The current year	14a	
	b The plan year immediately preceding the current plan year	14b	
	C The second preceding plan year	14c	
15	Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to ma employer contribution during the current plan year to:	ike an	
	a The corresponding number for the plan year immediately preceding the current plan year	15a	
	b The corresponding number for the second preceding plan year	15b	
16	Information with respect to any employers who withdrew from the plan during the preceding plan year.	•	
	a Enter the number of employers who withdrew during the preceding plan year	16a	
	b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	
17	If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, c supplemental information to be included as an attachment.		
Ρ	art VI Additional Information for Single-Employer and Multiemployer Defined Benef	it Pens	ion Plans
18	If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see ir information to be included as an attachment	structior	s regarding supplemental
19	If the total number of participants is 1,000 or more, complete items (a) through (c)		
	 a Enter the percentage of plan assets held as: Stock:% Investment-Grade Debt:% High-Yield Debt:% Real Estate: b Provide the average duration of the combined investment-grade and high-yield debt: 0-3 years 0 3-6 years 0 6-9 years 0 9-12 years 1 12-15 years 1 15-18 years 1 18-1 c What duration measure was used to calculate item 19(b)? 		
	Effective duration Macaulay duration Modified duration Other (specify):		

5500 Electronic Filing Authorization

Plan Name:Niagara Hospitalist, PC 401(k)/Profit Sharing Plan & TrustEIN/PN:20-1993782/001Plan 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 Administrator	Plan
(sign)	(sign
$\frac{9-13-12}{(date)}$	(date

Sponsor Meis-

Form 5500	Annual Return/Report of Employe	e Benefit Plan	OMB N	os. 1210-0110 1210-0089
Department of the Treasury	This form is required to be filed for employee benefit pl and 4065 of the Employee Retirement Income Security	ans under sections 104 Act of 1974 (ERISA) and		
Internal Revenue Service Department of Labor Employee Benefits Security Administration	sections 6047(e), 6057(b), and 6058(a) of the Internal Re Complete all entries in accordance	evenue Code (the Code).	2011	
Pension Benefit Guaranty Corporation	the Instructions to the Form 550	JO.	This Form is Open to inspection	Public
	Identification Information	·····		
For the calendar plan year 201	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;	the final return/repor	t;	
•	an amended return/report;	a short plan year ret	urn/report (less than 12 m	onihs).
C If the plan is a collectively-barg	jained plan, check here			🗋
D Check box if filing under:	Form 5558;	automatic extension	the DFVC pr	manoo:
	special extension (enter description)			-3
Part II Basic Plan Info	rmation enter all requested information.			
1a Name of plan	mation enter an requested anomation.		1b Three-digit plan	
	L, PC 401(k)/Profit Sharing Plan & Trust	1	number (PN)	001
Nidgara Noprealis.			1C Effective date of pla 01/01/2006	in
2a Plan sponsor's name and ad	ddress, including room or suite number (Employer, if for sing	gle-employer plan)	2b Employer Identificat	lion
			Number (EIN)	
Niagara Hospitalist	t, PC		20-1993782	
			2C Sponsor's telephone	e
			(716) 828-243	
			2d Business code (see	.
4201 N. Buffalo Roa	ad		instructions)	
US Orchard Park	NY 14127		621111	
vo vruidru ratk	••• ••••			
				5
Caution: A penalty for the late of	r incomplete filing of this return/report will be assessed	unless reasonable cause is	s established.	

Under penalty of the faite of merchants 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	When the	9-13-12	John A. Brach, MD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	$\mathcal{T}_{\mathcal{H}}(h)$	9-13-12	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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	Form 5500 (2011)	Page 2			
3a	Plan administrator's name and address (if same as plan sponsor, enter "Same") Same		3b A	dministrator's EIN	
	29ma			dministrator's tele umber	phone
					. <u></u>
4	If the name and/or EIN of the plan sponsor has changed since the last return/report file the plan number from the last return/report:	d for this plan, enter the name, EIN and		4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year	· · · · · · · · · · · · · · · · · · ·	5		6
6	Number of participants as of the end of the plan year (welfare plans complete or		-		
а	Active participants		<u>6a</u>		6
b	Retired or separated participants receiving benefits		6b		
С	Other retired or separated participants entitled to future benefits		6c		
	Subtotal. Add lines 6a, 6b, and 6c		6d		
e	Deceased participants whose beneficiaries are receiving or are entitled to receive	ve benefits	6e		6
f	Total. Add lines 6d and 6e		6f		
g	Number of participants with account balances as of the end of the plan year (on complete this item)		6g		6
h	Number of participants that terminated employment during the plan year with a less than 100% vested		6h		
7	Enter the total number of employers obligated to contribute to the plan (only mu	ultiemployer complete this item)	7		÷
88	If the plan provides pension benefits, enter the applicable pension feature cod	es from the List of Plan Characteristic Cod	les in tl	ne instructions:	
	2E 2G 2J 2K 3D 3H				
-	b If the plan provides welfare benefits, enter the applicable welfare feature code	s from the List of Plan Characteristic Code	es in the	e instructions:	
98	Plan funding arrangement (check all that apply)	B Plan benefit arrangement (check all th	nat app	ly)	
	(1) X Insurance	(1) x insurance		otracte	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) insura (3) X Trust	ance co	amacis	
	(3) X Trust	(3) X Trust (4) General assets of the sponso)r		
10	(4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached.			e instructions)	
		b General Schedules			
a	(4) R (Retirement Plan Information)	(1) H (Financial Inform	nation)		

(1) x R (Relirement Plan Information)	(1)	H (Financial Information)
(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Information - Small Plan)
Purchase Plan Actuarial Information) - signed by the plan	(3) X	1 A (Insurance Information)
actuary	(4)	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)	G (Financial Transaction Schedules)

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)				ОМ	B No. 1210-0110		
Department of the Treasury Internal Revenue Service	,	This schedule is requestion Employee Retirement In	uired to be filed under come Security Act of			2011	
Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Corport	ration	Insurance companies an pursuant to l	e required to provide t ERISA section 103(a)		n	This F	orm is Open to Public Inspection.
For calendar plan year 2011	l or fiscal	plan year beginning 01/01/2	011	and ending	12/31	/2011	
A Name of plan				B Three-diplan num	git 1ber (PN)	•	001
Niagara Hospitalist,	PC 40	l(k)/Profit Sharing Pla	n & Trust				
C Plan sponsor's name as shown on line 2a of Form 5500.				D Employer Indentification Number (EIN)			
Niagara Hospitalist,	PC				20-1993782		
Part I Information on a separate S 1 Coverage Information:	Concern chedule A	ning Insurance Contract Co Individual contracts grouped as a	overage, Fees, and unit in Parts II and III	d Commise can be report	sions Provid ed on a single	le information Schedule A.	n for each contract
(a) Name of insurance carrie	er						
NATIONWIDE LIFE INSU	IRANCE (со.					
	(c) NAIC	(d) Contract or	(e) Approximate			Policy or	contract year
(b) EIN	code	identification number	persons covere policy or con		(f) Fro	m	(g) To
31-4156830 66869 0000NIAG00NY00K				3	12/1/20	011	12/31/2011
2 Insurance fee and com descending order of the		formation. Enter the total fees and baid.	total commissions pa	id. List in item	3 the agents,	brokers, and	other persons in
		commissions paid		(b) Tota	I amount of fe	es paid	
		0				0	
3 Persons receiving com	missions a	ind fees. (Complete as many entrie	es as needed to repor	t all persons).			
	(a) Name	and address of the agent, broker,	or other person to wh	om commissi	ons or fees we	ere paid	

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

(b) Amount of sales and base	Fees ar		
commissions paid	(C) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice a	and OMB Control Numbers, see th	e Instructions for Form 5500.	Schedule A (Form 5500) 2011

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(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 were 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	Fees a		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
Construction of the Constr			

(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 were paid

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

Schedule A (Form 5500) 2011

Pa	The second secon	dividual contracts with each carrier m	ay be treated	as a unit for purposes of
4	Current value of plan's interest under this contract in the general account at ye	ar end	4	
5	Current value of plan's interest under this contract in separate accounts at year		5	80,314
6	Contracts With Allocated Funds: a State the basis of premium rates NOT PROVIDED BY INSURANCE CO.			
	b Premiums paid to carrier		6b	5,000
	C Premiums due but unpaid at the end of the year		6c	
	d If the carrier, service, or other organization incurred any specific costs in or or retention of the contract or policy, enter amount	onnection with the acquisition	6d	80
	Specify nature of costs			
	CONTRACT COMMISSIONS			
	e Type of contract (1) x individual policies (2) group deferred	annuity		
	(3) other (specify)			
	_			
	a second s	ingting plan check here	►	
	f If contract purchased, in whole or in part, to distribute benefits from a term Contracts With Unallocated Funds (Do not include portions of these contract	maintained in separate accounts)		
'		immediate participation guarantee		
é		• • •		
	(3) guaranteed investment (4)	other 🕨		
	b Balance at the end of the previous year	· 7c(1) · 7c(2) · 7c(3) · 7c(4)	7b	
	(5) Other (specify below)	· <u>7c(5)</u>		
	(C) Total additions		7c(6)	
	(6) Total additions	• • • • • • • <u>• • • • • • •</u>	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)	· 7e(4)		
	F		ting", in the	
			:	
		·	7-18	
	(5) Total deductions		7e(5)	
	f Balance at the end of the current year (subtract e(5) from d).		_7f	

	Schedule A (Form 5500) 2011	<u> </u>	Pag	je 4				
Pai	Welfare Benefit Contract Information If more than one contract covers the same group of em information may be combined for reporting purposes if the entire group of such individual contracts with each of	such contracts are experi	ience-rated as a ur	hit. Where con	tracts co			
8	Benefit and contract type (check all applicable boxes)		-			-		
	a 📙 Health (other than dental or vision) b 📃 D	ental	C 📋 Vision		d		surance	
	e 🗌 Temporary disability (accident and sickness) 🛛 f 🗌 Lo	ong-term disability	g 🔄 Supplementa	il unemployme	ent h	Presci	ription dr.	Ъ
	i Stop loss (large deductible) j H	MO contract	k 🗌 PPO contract	t	1		nity contr	ract
	m Other (specify) ►							
9	Experience-rated contracts:	_						
а	Premiums: (1) Amount received		9a(1)			1 ·		E.
	(2) Increase (decrease) in amount due but unpaid	· · · · · ·	9a(2)					
	(3) Increase (decrease) in unearned premium reserve .	· · · · · L	9a(3)		- (4)	<u> </u>		
	(4) Earned ((1) + (2) - (3))	· · · · · · · ·	01-(4)	9	<u>a(4)</u>			
b	Benefit charges: (1) Claims paid		<u>9b(1)</u>					
	(2) Increase (decrease) in claim reserves	• • • • • • L	9b(2)		L/2)		······	
	(3) Incurred claims (add (1) and (2))				b(3) b(4)			
	(4) Claims charged	•••••	•••••	•••	<u>D(4)</u>			
C	Remainder of premium: (1) Retention charges (on an accrual		9c(1)(A)					
	(A) Commissions		9c(1)(B)					
			9c(1)(C)	·				
	(C) Other specific acquisition costs	-1	9c(1)(D)			.s.,		
		F	9c(1)(E)					
	(E) Taxes		9c(1)(F)	-			·	
	(G) Other retention charges	– – – – – – – – – – – – – – – – – – –	9c(1)(G)					
	(H) Total retention		· · · · · ·	9c(1)(H)			
	(2) Dividends or retroactive rate refunds. (The amounts were	e 🗌 paid in cash, or	credited.)	90	:(2)			
d	Status of policyholder reserves at end of year: (1) Amount he	Id to provide benefits aft	er retirement	90	1(1)			
-	(2) Claim reserves			90	1(2)			
	(3) Other reserves				:(3)			
е	Dividends or retroactive rate refunds due. (Do not include am	ount entered in c(2).)	<u></u>		9e			
10	Nonexperience-rated contracts:						:	
а	Total premiums or subscription charges paid to carrier				<u>0a</u>			
b	If the carrier, service, or other organization incurred any speci	lic costs in connection wi	ith the acquisition o	n [. 1			
	retention of the contract or policy, other than reported in Part I	, item 2 above, report an	nount	[1	0b	-		
Sp	ecify nature of costs 🕨							

PartIV Provision of Information			 	
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	 F	Yes	No	
12 If the assume to lice 11 in Type I appoint the information not provided				

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

	SCHEDULE I	Financial Inform	ation S	mall Plan	OMB No. 1210-0110		
				ed under section 104 of the Employee			
	Department of the Treasury Internal Revenue Service	974 (ERISA) e Code (the C	and section 60 Code).)58(a) of the		2011	
	Department of Labor nployeo Benefits Security Administration	► File as an attach	ment to For	m 5500.			n is Open to Public
	Pension Benefit Guaranty Corporation					[nspection.
	calendar plan year 2011 or fiscal plan	year beginning 01/01/2011		and ending			
	Name of plan	_			B Three-digit		
	Niagara Hospitalist, PC 4	01(k)/Profit Sharing Plan &	Trust	ŀ	plan number	(PN) 🕨	001
				2			
С	Plan sponsor's name as shown on lin	e 2a of Form 5500			D Employer Ide	ntification Nur	nber (EIN)
	Niagara Hospitalist, PC				20-199378		
		ver than 100 participants as of the beginn	ing of the play	n vear. You ma	av also complete S	Schedule I if v	ou are filing as a
small	blan under the 80-120 participant rule	(see instructions). Complete Schedule H	if reporting as	s a large plan	or DFE.	,	
	rt I Small Plan Financial						
benefi	t at a future date. Include all income a nce carriers. Round off amounts to t	nter the value of the portion of an insurar and expenses of the plan including any th he nearest dollar.	ust(s) or sepa	rately maintair	ned fund(s) and an	by payments/n	eceipts to/from
1	Plan Assets and Liabilities:			(a) Beginnin	ig of Year	(b) End o	of Year
			1a	(a) Beginnin	ng of Year 402 , 427	(b) End o	
1	Total plan assets	· · · · · · · · · · · · · · · · ·	1a 1b	(a) Beginnin		(b) End o	of Year 193,986 0
1 a b	Total plan assets Total plan liabilities		1b	(a) Beginnin	402,427	(b) End o	
1 a b	Total plan assets Total plan liabilities		1b	(a) Beginnin (a) Amou	402,427 0 402,427	(b) End c	193,986 0 193,986
1 a b c	Total plan assets		1b 1c		402,427 0 402,427		193,986 0 193,986
1 b <u>c</u> 2	Total plan assets	n line 1a)	1b 1c		402,427 0 402,427		193,986 0 193,986
1 b <u>c</u> 2	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2)		402,427 0 402,427 unt		193,986 0 193,986
1 b <u>c</u> 2	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3)		402,427 0 402,427 unt 0		193,986 0 193,986
1 b <u>c</u> 2	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b		402,427 0 402,427 unt 0		193,986 0 193,986
1 a b c 2 a	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c		402,427 0 402,427 unt 0		193,986 0 193,986 otal
1 b c 2 a b	Total plan assetsTotal plan liabilitiesNet plan assets (subtract time 1b fromIncome, Expenses, and TransferContributions received or receivable(1) Employers(2) Participants(3) Others (including rollovers)Noncash contributions	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d		402,427 0 402,427 unt 0 8,877		193,986 0 193,986 otal
1 b c 2 a b c	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d 2c 2d 2e		402,427 0 402,427 unt 0 8,877		193,986 0 193,986 otal
1 a b c 2 a b c d	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d		402,427 0 402,427 unt 0 8,877 (5,174)		193,986 0 193,986 otal
1 a b c 2 a b c d	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d 2c 2d 2e 2f		402,427 0 402,427 unt 0 8,877 (5,174)		193,986 0 193,986 otal
1 b c 2 a b c d e f g	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d 2c 2d 2e 2f 2g		402,427 0 402,427 unt 0 8,877 (5,174) 210,907		193,986 0 193,986 otal
1 b c 2 a b c d e f g	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d 2c 2d 2c 2d 2e 2f 2g 2h		402,427 0 402,427 unt 0 8,877 (5,174)		193,986 0 193,986 otal
1 b c 2 a b c d e f g	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d 2c 2d 2c 2d 2e 2f 2g 2h 2i		402,427 0 402,427 unt 0 8,877 (5,174) 210,907		193,986 0 193,986 Dtal 3,703
1 b c 2 a b c d e f g	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d 2c 2d 2c 2d 2c 2d 2c 2d 2f 2f 2j		402,427 0 402,427 unt 0 8,877 (5,174) 210,907		193,986 0 193,986 Dtai 3,703 212,144
1 b c 2 a b c d e f g	Total plan assets	n line 1a)	1b 1c 2a(1) 2a(2) 2a(3) 2b 2c 2d 2c 2d 2c 2d 2e 2f 2g 2h 2i 2j 2k		402,427 0 402,427 unt 0 8,877 (5,174) 210,907		193,986 0 193,986

		Yes	No	Amount
а	Partnership/joint venture interests		x	
b	Employer real property		X	
c	Real estate (other than employer real property)		x	
d	Employer securities		х	
	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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Schedule I (Form 5500) 2011

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			Yes	No	An	nount	
3f	Loans (other than to participants)	3f		х			
9	Tangible personal property	<u>3g</u>	<u> </u>	X			
Part	Compliance Questions						
4	During the plan year:		Yes	No	An	nount	
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)	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	1 100	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?	<u>4e</u>	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?	<u>4g</u>		x	5 - A		
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?	41		x			
J	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		x			
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No", attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	x			· .	
I.	Has the plan failed to provide any benefit when due under the plan?	41	<u> </u>	x			
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	<u>4m</u>	<u>x</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	4n	x				
5 a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?	_	_				
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	es 🛛	No	Amount	:		
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the p transferred. (See instructions.)	an(s) te	o which as	ssets or lia	ibilities were		
	5b(1) Name of plan(s)	5	b(2)	EIN(s)		5b(3)	PN(s)

SCHE	DULE R	Retirement Plan Information		_	MB No. 1210-0110		
Department	n 5500) cf the Treasury avenue Service	Treasury This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section					
Employee Benefit	nent of Labor s Security Administration	 ► File as an Attachment to Form 5500. 			This Fo	orm is Open to P Inspection.	ublic
	year 2011 or fiscal p	lan year beginning 01/01/2011 and er	nding	12/	31/201	1	
A Name of plan Niagara Hos	spitalist, PC 4	01(k)/Profit Sharing Plan & Trust	5	hree-digil blan num PN)		001	L
C Plan sponsor's	name as shown on li	ne 2a of Form 5500	DΕ	mployer	Identificat	tion Number (EIN	1)
Niagara Hos	spitalist, PC			20-199	3782		
	ributions						
All references to	o distributions relate	only to payments of benefits during the plan year.					
	of distributions paid in	property other than in cash or the forms of property specified in the		. 1			
2 Enter the Ell payors who	paid the greatest dolla	aid benefits on behalf of the plan to participants or beneficiaries during ar amounts of benefits):	the yea	r (if more	than two,	, enter EINs of the	i two
EIN(s):	95-28343	236					
Profit-shari	ng plans, ESOPs, ar	nd stock bonus plans, skip line 3.					
year		eceased) whose benefits were distributed in a single sum, during the	••				
	unding Informati	On (If the plan is not subject to the minimum funding requirements this Part)	of secti	ion 412 0	f the Inte	rnal Revenue Co	de or
		an election under Code section 412(d)(2) or ERISA section 302(d)(2))?	· [] Yes	No No	🗌 N/A
If the plan i	s a defined benefit p	lan, go to line 8.					
plan year, se	ee instructions and en	g standard for a prior year is being amortized in this tter the date of the ruling letter granting the waiver. Date: Mont			Day	Year	
If you comp	leted line 5, complet	e lines 3, 9, and 10 of Schedule MB and do not complete the rema	ninder o	f this scl	<u>nedule.</u>		
deficien	cy not waived)	contribution for this plan year (include any prior year accumulated fur	nding • •	. 6a			
b Enter th	ne amount contributed	by the employer to the plan for this plan year	••	. <u>6b</u>			
C Subtrac (enter a	t the amount in line 6 minus sign to the left	b from the amount in line 6a. Enter the result t of a negative amount)	••	. <u>6</u> c			
If you com	pleted line 6c, skip li	nes 8 and 9.					
7 Will the min	imum funding amoun	t reported on line 6c be met by the funding deadline?	•••] Yes	No	N/A
authority pro	in actuarial cost meth oviding automatic app or agree with the chan	od was made for this plan year pursuant to a revenue procedure or a roval for the change or a class ruling letter, does the plan sponsor on the second secon	r plan] Yes	No	
Armed and the state of the state of the	mendments						
9 If this is a d year that in	efined benefit pension creased or decreased	the value of benefits? If yes, check the appropriate	Base	De	crease	🔲 Both	🗌 No
box. If no, c	ESOPs (see inst	ructions). If this is not a plan described under Section 409(a) or 497		of the Inte	ernal Rev	enue Code,	
10 Were unallo	skip this Part.	rities or proceeds from the sale of unallocated securities used to rep	ay any	exempt l	oan? .	🗌 Yes	
	the ESOP hold any pi		• •		• • •	🗌 Yes	No No
					•		
b If the (See	instructions for definit	ding exempt loan with the employer as lender, is such loan part of a ion of "back-to-back" loan.)	"back-to	-back" lo	<u></u>	Yes	□ No □ No

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Page 3

	Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:
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	a The current year	14a					
	b The plan year immediately preceding the current plan year	14b					
	C The second preceding plan year	14c					
15	Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make employer contribution during the current plan year to:	an					
	a The corresponding number for the plan year immediately preceding the current plan year	15a					
	b The corresponding number for the second preceding plan year	15b					
16	Information with respect to any employers who withdrew from the plan during the preceding plan year:						
	a Enter the number of employers who withdrew during the preceding plan year	16a					
	b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b					
17	If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, cheory supplemental information to be included as an attachment.	ck box and	see instructions regarding				
Pa	art VI Additional Information for Single-Employer and Multiemployer Defined Ben	nefit Pen	sion Plans				
18	If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or i and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instr information to be included as an attachment	n part) of li uctions reg	abilities to such participants arding supplemental				
19	If the total number of participants is 1,000 or more, complete items (a) through (c)						
	Enter the percentage of plan assets held as: Stock:% Investment-Grade Debt:% High-Yield Debt:% Real Estate:		% Other:%				
	b Provide the average duration of the combined investment-grade and high-yeild debt:	-21 years	21 years or more				
	C What duration measure was used to calculate item 19(b)?						

Application for Extension of Time To File Certain Employee Plan Returns

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

File With IRS Only

Part I Identification

-	Name of Flor, also administrator, or also approach (and instructiona)			ា រោធារា	iying number ((19)	
A	Name of filer, plan administrator, or plan sponsor (see instructions)	l°.	B Filer's Identifying number (see instructions)					
	Niagara Hospitalist, PC Number, street, and room or suite no. (If a P.O. box, see instructions)	-1	Employer identification number (EIN)					
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Par	t II Extension of Time To File Form 5500 Series, and/or Form 8955	SSA						
1	I request an extension of time until10 / 15 / 2012 to file Form	5500 s	eries	(see ins	tructions).			
	Note. A signature IS NOT required if you are requesting an extension to file Form 5500							
	······································							
2	I request an extension of time until to file Form	8955-5	SA (s	ee instr	uctions).			
	Note. A signature IS required if you are requesting an extension to file Form 8955-SSA	۱.						
	The application is automatically approved to the date shown on line 1 and/or line 2 (a the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extens	above) ion is r	if: (a) eques	the For	n 5558 is fileo J (b) the date	1 on or before on line 1		
Par	The application is automatically approved to the date shown on line 1 and/or line 2 (a the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extense and/or line 2 (above) is not later than the 15th day of the third month after the normal of IIII Extension of Time To File Form 5330 (see instructions)	ion is r	eques	the Forr ted, and	n 5558 is fileo d (b) the date	d on or before on line 1		
Pari 3	the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extense and/or line 2 (above) is not later than the 15th day of the third month after the normal of Extension of Time To File Form 5330 (see instructions)	ion is n lue date	eques	ted, and	d (b) the date	d on or before on line 1		
	the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extense and/or line 2 (above) is not later than the 15th day of the third month after the normal of Extension of Time To File Form 5330 (see instructions)	ion is n lue date	eques	ted, and	d (b) the date	d on or before on line 1		
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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 automzed to prepare this application.