	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110
Form 5500	This form is required to be filed for employee benefit plans under sections 104	1210-0089
Department of the Treasury Internal Revenue Service	and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).	2011
Department of Labor 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
Part I Annual Report Ider	tification Information	
For calendar plan year 2011 or fiscal	plan year beginning 01/01/2011 and ending 12/31/2	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 the	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 AURORA HOSPITALIST, PC 401(K)/	PROFIT SHARING PLAN	1b Three-digit plan number (PN) ►
		1c Effective date of plan 01/01/2003
2a Plan sponsor's name and addres AURORA HOSPITALIST, PC	s, including room or suite number (Employer, if for single-employer plan)	2b Employer Identification Number (EIN) 56-2305169
		2c Sponsor's telephone number 716-655-3846
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.	09/29/2012 Date	JOHN A BRACH MD Enter name of individual signing as plan administrator
		Date	Enter hame of individual signing as plan autilitistrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/29/2012	JOHN A BRACH MD
HERE	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
AU	RORA HOSPITALIST, PC		-2305169
	01 N. BUFFALO ROAD CHARD PARK, NY 14127		ministrator's telephone
UR	CHARD PARK, NY 14127	110	716-655-3846
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	41
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
-		60	37
а	Active participants	6a	57
b	Retired or separated participants receiving benefits	6b	0
~	Other retired or experted participants entitled to future herefite	6c	3
C	Other retired or separated participants entitled to future benefits		
d	Subtotal. Add lines 6a, 6b, and 6c	6d	40
۵	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
U			
f	Total. Add lines 6d and 6e	6f	40
q	Number of participants with account balances as of the end of the plan year (only defined contribution plans		
3	complete this item)	6g	15
h	Number of participants that terminated employment during the plan year with accrued benefits that were		
	less than 100% vested	6h	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2G 2J 2K 3D 3H

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a	a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)							
	(1)	X	Insurance		(1) Insurance			
	(2)		Code section 412(e)(3) insurance contracts		(2)	2) Code section 412(e)(3) insurance contracts		
	(3)	X	Trust		(3)	(3) X Trust		
	(4)		General assets of the sponsor		(4)	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	Pensic	on <u>S</u> cl	nedules	b	General	Sc	hedules	
	(1)	X	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)	Π	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	Α	Insuran	ce Informatio	n		ОМ	IB No. 1210-0110
(Form 5500 Department of the Treas	sury	This schedule is required	l to be filed under section	on 104 of th	e		
Internal Revenue Serv		Employee Retirement Inc	come Security Act of 19	974 (ERISA)).		2011
Department of Labor Employee Benefits Security Ad		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion		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	1
A Name of plan AURORA HOSPITALIST,	PC 401(K)/PR	OFIT SHARING PLAN			e-digit number (P	'N) 🕨	001
C Plan sponsor's name a AURORA HOSPITALIST,		e 2a of Form 5500		D Emplo 56-230	•	cation Number ((EIN)
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
NATIONWIDE LIFE INSU	IRANCE CO.						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)) From	(g) To
31-4156830	66869	0000AURO00NY00K		11	01/01/20	011	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	s, brokers, and c	other persons in
(a) Total a	amount of comr	nissions paid		(b) To	tal amount	t 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 commissi	ions or fees	s were paid	
(b) Amount of sales ar	nd base		s and other commissio				-
commissions pai	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commisei	ions or fee	s were naid	
		na address of the agent, broker,				o more paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	e and OMB Control Numbers,	see the instructions for Form 5500. Sche	dule 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 commissions paid	Fees and other 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 commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	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 commissions paid		(e) Organization	
	(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 each carrier ma	v ha traatad as	a unit for purposes of
		this report.	ly de llealeu as	a unit for purposes of
4	Curi	rent value of plan's interest under this contract in the general account at year end	. 4	0
5	Curi	rent value of plan's interest under this contract in separate accounts at year end		392019
6		tracts With Allocated Funds:		
	а	State the basis of premium rates NOT PROVIDED BY INSURANCE CO		
	h		Ch	10100
	b	Premiums paid to carrier	. 6b	13133
	c d	Premiums due but unpaid at the end of the year	6c	0
	u	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	741
		Specify nature of costs CONTRACT COMMISSIONS	L	
	е	Type of contract: (1) 🕅 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		
	u			
		(3)		
	b	Balance at the end of the previous year	. 7b	
	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 year (subtract e(5) from d)	. 7f	

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 group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employee							
		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 reported in Part I, item 2 above, report amount								

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	,			Thio	Form is Open to Bublic	
	Pension Benefit Guaranty Corporation	File as a	an attac	hment to Form	5500.			inis	Form is Open to Public Inspection	
For	calendar plan year 2011 or fiscal p	lan year beginning 01/01/201	1		a	and ending	12/3	31/2011		
	Name of plan ORA HOSPITALIST, PC 401(K)/PF	ROFIT SHARING PLAN				Three-digit plan numb		•	001	
	Plan sponsor's name as shown on ORA HOSPITALIST, PC	line 2a of Form 5500				mployer Id 2305169	lentificatio	on Numbe	er (EIN)	
	nplete Schedule I if the plan covered all plan under the 80-120 participant							ete Scheo	dule I if you are filing as a	
Pa	art I Small Plan Financial	Information								
ass ben	port below the current value of asse ets held in more than one trust. Do hefit at a future date. Include all inco urance carriers. Round off amount	not enter the value of the portion ome and expenses of the plan inc	of an in	surance contrac	t that g	guarantees	during th	is plan ye	ear to pay a specific dollar	
1	Plan Assets and Liabilities:			(a) Be	eginning	g of Year			(b) End of Year	
а	Total plan assets		. 1a			5	41351		512974	
b	Total plan liabilities		. 1b				0			
С	Net plan assets (subtract line 1b f	rom line 1a)	_ 1c			5	41351		512974	
2	Income, Expenses, and Transfe	ers for this Plan Year:		((a) Amo	ount			(b) Total	
а	Contributions received or receivable	ole:								
	(1) Employers		. 2a(1)							
	(2) Participants		. 2a(2)				12366			
	(3) Others (including rollovers)		2a(3)							
b	Noncash contributions		. 2b							
С	Other income		. 2c				21506			
d	Total income (add lines 2a(1), 2a((2), 2a(3), 2b, and 2c)	. 2d						-9140	
е	Benefits paid (including direct rollo						18335			
f	Corrective distributions (see instru						662			
g	Certain deemed distributions of pa	,								
•	(see instructions)		. 2g							
h	Administrative service providers (s	salaries, fees, and commissions).	. 2h							
i	Other expenses		. 2i				240			
j	Total expenses (add lines 2e, 2f, 2	2g, 2h, and 2i)	. 2j						19237	
k	k Net income (loss) (subtract line 2j from line 2d) 2k						_		-28377	
I	Transfers to (from) the plan (see i	nstructions)	. 2 I							
3	Specific Assets: If the plan held a remaining in the plan as of the end c by-line basis unless the trust meets of	of the plan year. Allocate the value o	of the pla	n's interest in a co		led trust co	ntaining th		of more than one plan on a line-	
_					_	Yes	No X		Amount	
a ⊾	Partnership/joint venture interests				3a		×			
b	Employer real property				3b					
С	Real estate (other than employer	real property)			3c		X			
d	Employer securities				3d		Х			
е	Participant loans				3e		X			
For	Paperwork Reduction Act Notice	e and OMB Control Numbers, s	ee the i	nstructions for	Form	5500		:	Schedule I (Form 5500) 201	

chedule	I (⊢orm	5500)	2011
		v.01	2611

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

Pa	Part II Compliance Questions				
4	During the plan year:		Yes	No	Amount
а	a Was there a failure to transmit to the plan any participant contributions within the described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year f corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program	ailures until fully		X	
b	b Were any loans by the plan or fixed income obligations due the plan in default as year or classified during the year as uncollectible? Disregard participant loans se participant's account balance.	ecured by the		X	
С	C Were any leases to which the plan was a party in default or classified during the uncollectible?			х	
d	d Were there any nonexempt transactions with any party-in-interest? (Do not inclure reported on line 4a.)			x	
е	e Was the plan covered by a fidelity bond?	4e	Х		50000
f	f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, t fraud or dishonesty?			×	
g	g Did the plan hold any assets whose current value was neither readily determinal market nor set by an independent third party appraiser?			X	
h	h Did the plan receive any noncash contributions whose value was neither readily established market nor set by an independent third party appraiser?			×	
i	i Did the plan at any time hold 20% or more of its assets in any single security, de of real estate, or partnership/joint venture interest?	00/1		×	
j	j Were all the plan assets either distributed to participants or beneficiaries, transfe or brought under the control of the PBGC?			×	
k	k Are you claiming a waiver of the annual examination and report of an independent of accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or statement. (See instructions on waiver eligibility and conditions.)	2520.104-50	X		
I	Has the plan failed to provide any benefit when due under the plan?			Х	
m	M If this is an individual account plan, was there a blackout period? (See instruction 2520.101-3.).		X		
n	n If 4m was answered "Yes," check the "Yes" box if you either provided the require the exceptions to providing the notice applied under 29 CFR 2520.101-3		X		
5a	A Has a resolution to terminate the plan been adopted during the plan year or any If "Yes," enter the amount of any plan assets that reverted to the employer this		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 OMB No. 1210-							10-0110				
(Form 5500) Department of the Treasury This schedule is required										201	1	
	Internal Re	evenue Service		nent Income Security a) of the Internal Rever			section		T L'- F			
E	Employee Benefits Security Administration Pension Benefit Guaranty Corporation						Inspect	en to Pub ion.	lic			
For		year 2011 or fiscal p	lan year beginning	01/01/2011		and end	ding	12/31/2	011			
	lame of plan ORA HOSPIT	ALIST, PC 401(K)/PF	ROFIT SHARING PLAN	١				e-digit n numbe I)	ir	(001	
	Plan sponsor's ORA HOSPIT	a name as shown on li TALIST, PC	ine 2a of Form 5500					loyer Ide -230516		on Numb	er (EIN)	
Ра	rt I Dist	ributions										
All	references to	o distributions relate	only to payments of	benefits during the p	olan year.							
1			property other than in					1				
2			paid benefits on behalf ar amounts of benefits)		ants or beneficiarie	es durin	g the year	r (if more	e than tw	vo, enter	EINs of the	e two
	EIN(s):	31-4156830		-	95-2834236							
	Profit-shari	ng plans, ESOPs, ar	nd stock bonus plans	, skip line 3.			F					
3			deceased) whose bene					3				
Pa		unding Informati RISA section 302, skip	i on (If the plan is not s o this Part)	subject to the minimum	n funding requirem	nents of	section of	f 412 of	the Inte	rnal Reve	enue Code	or
4	Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?											
	If the plan is	s a defined benefit p	olan, go to line 8.									
5	plan year, se	ee instructions and en	g standard for a prior y nter the date of the rulir	g letter granting the w	aiver. Date:				У		′ear	
~			te lines 3, 9, and 10 o				Г	this sc	hedule.			
6			ontribution for this plan				-	6a				
		- /	by the employer to the				-	6b				
	c Subtract	the amount in line 6b	from the amount in lin	e 6a. Enter the result								
		-	of a negative amount).					6c				
7		oleted line 6c, skip li	nes 8 and 9. reported on line 6c be	mot by the funding de	adline?			_		-	_	-
		indin funding amount	reported on line oc be	mer by the funding de					Yes	1	No	N/A
8	authority pro	oviding automatic app	od was made for this p roval for the change or ge?	a class ruling letter, de	oes the plan spon	sor or p	lan	Π	Yes	۱ []	No [N/A
P		mendments	3									
9			plan, were any amend	Imanta adapted during	this plan							
3	year that inc	reased or decreased	the value of benefits?	If yes, check the appro	priate	Increas	se	Decre	ase	Botl	n []	No
Ра	rt IV	ESOPs (see instrustion skip this Part.	uctions). If this is not a	plan described under	Section 409(a) or	4975(e)	(7) of the	Interna	Reven	ue Code,		
10	Were unallo	cated employer secu	rities or proceeds from	the sale of unallocated	d securities used to	o repay	any exen	npt loan	?		Yes	No
11		• •	eferred stock?								Yes	No
	(See in	structions for definition	ling exempt loan with th on of "back-to-back" loa	n.)							Yes	No
12			at is not readily tradab								Yes	No
For	Paperwork F	Reduction Act Notice	e and OMB Control N	umbers, see the instr	ructions for Form	n 5500.			Sche	dule R (l	orm 5500 ⁻ v.0)) 2011)12611

Pa	Part V Additional Information for Multiemployer Defined Benefit Pension Plans						
13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (mean dollars). See instructions. <i>Complete as many entries as needed to report all applicable employers</i> .							
	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				
	е	сотр	ution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, te items $13e(1)$ and $13e(2)$.)				
		(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					
	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	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:% Other:% 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 12-15 years 15-18 years 18-21 years 21 years or more 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: AURORA HOSPITALIST, PC 401(K)/PROFIT SHARING PLAN EIN/PN: 56-2305169/001 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 Administrato l/In (sign) 9-29-12 (date)

Plan Spons llia)

(sign)

29-12 (dat

Form 5500	Annual Return/Report of Employe	OMB Nos. 1210-0110 1210-0089				
Department of the Treasury Internal Revenue Service	This form is required to be filed for employee benefit pla and 4065 of the Employee Retirement Income Security A sections 6047(e), 6057(b), and 6058(a) of the Internal Re	Act of 1974 (ERISA) and				
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 Inspection	o Public			
Part I Annual Report I	dentification Information					
For the calendar plan year 2011	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/report	rt;			
	an amended return/report;	a short plan year ret	um/report (less than 12 π	nonths).		
C If the plan is a collectively-barg	ained plan, check here			[]		
D Check box if filing under:	X Form 5558;	automatic extension	; 🛛 🗌 the DFVC p	rogram;		
	special extension (enter description)					
Part II Basic Plan Info	rmation enter all requested information.					
1a Name of plan			1b Three-digit plan			
AURORA HOSPITALIST,	PC 401(K)/PROFIT SHARING PLAN		number (PN) 🕨	001		
			1c Effective date of pla 01/01/2003	an		
	dress, including room or suite number (Employer, if for sing	le-employer plan)	2b Employer Identifica Number (EIN) 56-2305169	ation		
AURORA HOSPITALIST,	PC		2C Sponsor's telephon number (716) 655-384			
4201 N. BUFFALO ROP	מי		2d Business code (see instructions)	8		
US ORCHARD PARK	NY 14127		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	TAL MA	9-29-12	JOHN BRACH, MD
1.7423.542	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	(the Mite)	9-29-12	JOHN 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) v.012611

Form 5500 (2011) Page 2									
	Plan administrator's name and address (if same as plan sponsor, enter "Sar	ne")				3b Administrator's EIN 3c Administrator's telephone number			
	Same								
4	If the name and/or EIN of the plan sponsor has changed since the last return/repor the plan number from the last return/report:	t filed f	or this	plar	n, 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	41		
	Number of participants as of the end of the plan year (welfare plans comple								
	Active participants	•••	•••	•		6a	37		
b	Retired or separated participants receiving benefits		• •	•		6b	0		
с	Other retired or separated participants entitled to future benefits	••	••	•		6c	3		
d	Subtotal. Add lines 6a, 6b, and 6c	••	•••	•		6d	40		
9	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive	benef	its		6e			
-	Total. Add lines 6d and 6e	••	••	•		6f	40		
g	Number of participants with account balances as of the end of the plan year complete this item)	r (only	define	d c	ontribution plans • • • • • • • • • • • • •	6g	15		
h	Number of participants that terminated employment during the plan year will less than 100% vested					6h	0		
7	Enter the total number of employers obligated to contribute to the plan (only	r multie	employ	yer	complete this item)	7			
b	If the plan provides pension benefits, enter the applicable pension feature $2E$ 2G $2J$ 2K 3D 3H If the plan provides welfare benefits, enter the applicable welfare feature c		rom th	e L		in the	e instructions:		
9a		³⁰	(1)	Г	Insurance	. app			
	 (1) X Insurance (2) Code section 412(e)(3) insurance contracts 		(2)	Η	Code section 412(e)(3) insurar	nce co	ntracts		
	 (2) Code section 412(e)(3) insurance contracts (3) X Trust 		(3)	x	Trust				
	(4) General assets of the sponsor	1	(4)	H	General assets of the sponsor				
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attack	ned, an		re ir		ed. (Se	e instructions)		
	Pension Schedules	b			I Schedules				
а	(1) X R (Retirement Plan Information)	-	(1)	<mark>ה</mark>	H (Financial Informa	tion)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	XX	I (Financial Informa	-	Smali Pian)		
	Purchase Plan Actuarial Information) - signed by the plan		(3)	M	<u>1</u> A (Insurance Inform				
	actuary		(4)	Н	C (Service Provider				
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(5) 	Η	D (DFE/Participating G (Financial Transa	-			

Sponsor Location Information

Sponsor name: AURORA HOSPITALIST, PC Sponsor DBA name: Sponsor care of name:

4201 N. Buffalo Road

US Orchard Park NY 14127

SCHEDULE (Form 5500	••	Insur	ance Information	ation		OM	B No. 1210-0110		
Department of the Trea Internal Revenue Serv			is required to be filed under sections 104 of the ent Income Security Act of 1974 (ERISA).			2011			
Department of Labo Employee Benefits Security Ad		 File as an at 	ttachment to Form 5	500.					
Pension Benefit Guaranty Co	erporation	Insurance companies a pursuant to	re required to provide to ERISA section 103(a)(n	This Form is Open to Pul Inspection.			
For calendar plan year 2	011 or fiscal pla	an year beginning 01/01/2	2011	and ending	, 12/31	/2011			
A Name of plan		B Three-digit plan number (PN)				►	001		
AURORA HOSPITALIST, PC 401(K)/PROFIT SHARING			N						
C Plan sponsor's name as shown on line 2a of Form 5500.			. <u></u>	D Employe	D Employer Indentification Number (EIN)				
AURORA HOSPITALIST, PC					56-2305	5169			
		ng Insurance Contract C Individual contracts grouped as							
1 Coverage Informatio	on:								
(a) Name of insurance c	arrier								
NATIONWIDE LIFE IN		D .							
	(c) NAIC	(d) Contract or	(e) Approximate			Policy or	contract year		
(b) EIN	code	identification number	persons covere policy or cont		(f) Fro	m	(g) To		
31-4156830	66869	0000AURO00NY00K		11	1/1/201	.1	12/31/2011		
2 Insurance fee and co descending order of		rmation. Enter the total fees and id.	d total commissions pai	d. List in item	3 the agents,	brokers, and	other persons in		
		ommissions paid		(b) Tota	amount of fe	es paid			
	0 0								
3 Persons receiving co	ommissions and	d fees. (Complete as many entr	ies as needed to report	all persons).					
	(a) Name a	nd address of the agent, broke	r, or other person to whe	om commissio	ons or fees we	re paid			

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

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

Page 2-

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

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

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

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

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

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

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

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

(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

Par	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indi	vidual contracts with each carrier may be t	reated as a unit for purposes of
	this report.		
4 (Current value of plan's interest under this contract in the general account at yea	rend	·
	Current value of plan's interest under this contract in separate accounts at year	end	332,013
-	Contracts With Allocated Funds:		
а	State the basis of premium rates		
h	NOT PROVIDED BY INSURANCE CO	6	b 13,133
b c	Premiums paid to carrier		c 0
d		nnection with the acquisition	
	or retention of the contract or policy, enter amount		d741
	Specify nature of costs 🕨		
	CONTRACT COMMISSIONS		
е	Type of contract (1) 🗙 individual policies (2) 🗌 group deferred a	nnuity	
	(3) 📋 other (specify) 🕨		
			_
£	If contract purchased, in whole or in part, to distribute benefits from a termi	nating plan check here	
7	Contracts With Unallocated Funds (Do not include portions of these contracts	maintained in separate accounts)	
·a		immediate participation guarantee	
a		other 🕨	
			/b
	Balance at the end of the previous year		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)	
	(2) Dividends and credits	7c(3)	
	(3) Interest credited during the year	7c(4)	
	(4) Transferred from separate account	7c(5)	
	(5) Other (specify below)		
	▶		
			c(6)
	(6) Total additions		7d
d	Total of balance and additions (add b and c(6)) · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	
e	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
		7e(2)	
	(2) Administration charge made by carrier	- 7e(3)	
	(3) Transferred to separate account	7e(4)	
	(4) Other (specily below)		
	•		
			'e(5)
	(5) Total deductions		7f

m 5500) 2011 Schodulo A (Eo

	Schedule A (Form 5500) 2011 Page 4		
Par	If more than one contract covers the same group of employees of the same employer(s) or members of information may be combined for reporting purposes if such contracts are experience-rated as a unit. We the entire group of such individual contracts with each carrier may be treated as a unit for purposes of the	nere contracts o	oyee organization(s), the cover individual employees,
8	Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) b Dental c Vision a Health (other than dental or vision) b Dental c Vision e Temporary disability (accident and sickness) f Long-term disability g Supplemental uner i Stop loss (large deductible) j HMO contract k PPO contract m Other (specify) ►		d 🗌 Life insurance h 🗌 Prescription drug I 🔲 Indemnity contract
9 a b	Experience-rated contracts: Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unearned premium reserve (4) Earned ((1) + (2) - (3)) Benefit charges: (1) Claims paid	9a(4)	
c	(2) Increase (decrease) in claim reserves 9b(2) (3) Incurred claims (add (1) and (2))	9b(3) 9b(4)	
Ū	(A) Commissions. 9c(1)(A) (B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C) (D) Other expenses 9c(1)(C) (E) Taxes 9c(1)(C) (F) Charges for risks or other contingencies 9c(1)(E) (G) Other retention charges 9c(1)(C)		
d	 (H) Total retention (2) Dividends or retroactive rate refunds. (The amounts were paid in cash, or credited.) Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 	9c(1)(H) 9c(2) 9d(1)	
d	(2) Claim reserves	9d(2) 9c(3) 9e	
10 a	Nonexperience-rated contracts: Total premiums or subscription charges paid to carrier	10a	
b Sp	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount ecify nature of costs	10b	

Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes	No
12 If the answer to line 11 is "Yes," specify the information not provided.	

	SCHEDULE I	Financial Information Small Plan					OMB No. 1210-0110		
	(Form 5500)	This schedule is required to be filed	under section	on 104 of the	a Employee	•	2011		
	Department of the Treasury Internal Revenue Service		etirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).						
E	Department of Labor nployee Benefits Security Administration	► File as an attachm	ent to For	m 5500.			This F	orm is Open to Public	
	Pension Benefit Guaranty Corporation	1	· · ·					Inspection.	
	calendar plan year 2011 or fiscal plan	year beginning 01/01/2011		and endir	1	1/2011			
	Name of plan					e-digit	_		
	AURORA HOSPITALIST, PC 40	1(K)/PROFIT SHARING PLAN			<u>plan</u>	number (<u>PN)</u>	001	
						<u> </u>			
С	Plan sponsor's name as shown on lin	e 2a of Form 5500				•		Number (EIN)	
	AURORA HOSPITALIST, PC				-	230516			
Comp	lete Schedule I if the plan covered few	ver than 100 participants as of the beginnin (see instructions). Complete Schedule H if	ng of the plar	h year. You r	nay also co n or DEE	omplete S	ichedule I i	if you are filing as a	
P	and the second se		reporting as	s a laige plai	TO DE.				
		d liabilities, income, expenses, transfers an inter the value of the portion of an insuranc							
		and expenses of the plan including any trus							
insura	nce carriers. Round off amounts to t	he nearest dollar.				-,	,,,		
1	Plan Assets and Liabilities:			(a) Regine	ning of Yea		(b) En	d of Year	
•				(a) begini		1,351		512,974	
a b	Total plan assets		1b			0		512,574	
b			10 1c		E/	1,351		512,974	
2	Income, Expenses, and Transfe	n line 1a)	10	(a) Am		1,331	/h') Totai	
_	•••				ount		(0)		
а	Contributions received or receivable		2a(1)						
	(1) Employers					0.000			
	(2) Participants		<u>2a(2)</u> 2a(3)		L	2,366			
L	(3) Others (including rollovers) .		2a(3) 2b						
D	Noncash contributions		20 2c	<u> </u>		,506)			
ר ר		$\cdots \cdots $	20 2d	1	(21	,500)	· · · ·	(9,140)	
d	Total income (add lines 2a(1), 2a(2),		20 2e			8,335		(9,140)	
e	Benefits paid (including direct rollove		26 2f			662			
Г —	Corrective distributions (see instructi	•				002			
g	Certain deemed distributions of parti		2g				1997 - A		
h	(see instructions)		29 2h						
- n :	Administrative service providers (sal		2ii 2i			240			
1		2h, and 2i)	2j			240	· · · · ·	19,237	
J k		om line 2d)	2k			2		(28, 377)	
. N			21	1				(20,577)	
3		tructions)		l	'Yes" and er	ter the cu	rent value (of any assets	
3	remaining in the plan as of the end of the	a) plan year. Allocate the value of the plan's interest of the specific exceptions described in the instru- tion of the specific exceptions.	est in a comm	ingled trust co	intaining the	assets of	more than o	one plan on a line-	
					Yes	No	A	mount	
а	Partnershin/joint venture interests			3		x			
b					b	x	[
c		al property)			c	x		P= .	
ď		· · · · · · · · · · · · · · · · · · ·			d	x			
	······································							An	

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Schedule I (Form 5500) 2011

Page 2-	
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			Yes	No	Amount
3f	Loans (other than to participants)	3f		х	
g	Tangible personal property	3g		x	
Part	Compliance Questions				
4	During the plan year:		Yes	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)	4a		x	2
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	4b		x	n - Constantino de la constantino de l Constantino de la constantino de la cons Constantino de la constantino de la cons
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	San
e	Was the plan covered by a fidelity bond?	4e	x		50,000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		x	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		x	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		. 68 X	
1	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?	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?	4 <u>j</u>		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		x	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m	_ x	erd Les sources	
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	4 <u>n</u>	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	X	No	Amount	•
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.)	(s) to	which as	sets or lia	ibilities were

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)
		<u> </u>

SCHEDULE R	Retirement Plan Information		OMB No. 1210-0110				
(Form 5500) Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 and 4065 Employee Retirement Income Security Act of 1974 (ERISA) and	5 of the 1 section	e 2011				
Department of Labor Employoe Benefits Security Administration Pension Benefit Guaranty Corporation	6058(a) of the Internal Revenue Code (the Code). ► File as an Attachment to Form 5500.		This Form is Open to Public Inspection.				
For calendar plan year 2011 or fiscal p	blan year beginning 01/01/2011 and er	nding	12/31/20	11			
A Name of plan	01(K)/PROFIT SHARING PLAN	B Three- plan ((PN)	-digit number ►	00	1		
C Plan sponsor's name as shown on AURORA HOSPITALIST, PC	line 2a of Form 5500		oyer Identific 2305169	ation Number (Ell	N)		
Part Distributions							
	e only to payments of benefits during the plan year.						
instructions		[1				
2 Enter the EIN(s) of payor(s) who p payors who paid the greatest dol	baid benefits on behalf of the plan to participants or beneficiaries during lar amounts of benefits):	the year (if n	nore than tw	o, enter EINs of th	e two		
EIN(s): <u>31-4156</u>	i830 95-28 <u>34236</u>						
Profit-sharing plans, ESOPs, a	nd stock bonus plans, skip line 3.	_					
3 Number of participants (living or year	deceased) whose benefits were distributed in a single sum, during the		3				
Part II Funding Informat ERISA section 302, ski	ion (If the plan is not subject to the minimum funding requirements p this Part)	of section 4	12 of the In	ternal Revenue Co			
4 Is the plan administrator making If the plan is a defined benefit	an election under Code section 412(d)(2) or ERISA section 302(d)(2) plan, go to line 8.	?	🗌 Yes	No No	[]] N/A		
plan year, see instructions and e	ng standard for a prior year is being amortized in this nter the date of the ruling letter granting the waiver. Date: Mont		- /	Year			
6 a Enter the minimum required deficiency not waived) .	te lines 3, 9, and 10 of Schedule MB and do not complete the rema contribution for this plan year (include any prior year accumulated fur	inder of this nding 	6a				
b Enter the amount contributed	d by the employer to the plan for this plan year	• • • [6b				
C Subtract the amount in line 6 (enter a minus sign to the left	b from the amount in line 6a. Enter the result ft of a negative amount)		6c				
If you completed line 6c, skip I							
7 Will the minimum funding amour	at reported on line 6c be met by the funding deadline?	• • •	Yes	No No	N/A		
8 If a change in actuarial cost meth authority providing automatic app administrator agree with the change	hod was made for this plan year pursuant to a revenue procedure or or proval for the change or a class ruling letter, does the plan sponsor or nge?	r plan	Yes	No	<u>N/A</u>		
Part III Amendments			<u>. </u>				
9 If this is a defined benefit pensio year that increased or decreased box. If no, check the "No" box	n plan, were any amendments adopted during this plan d the value of benefits? If yes, check the appropriate	ease	Decrease	🔲 Both	No No		
Part IV ESOPs (see ins skip this Part.	tructions). If this is not a plan described under Section 409(a) or 4975						
10 Were unallocated employer secu	urities or proceeds from the sale of unallocated securities used to rep	ay any exem	pt loan?				
11 a Does the ESOP hold any p b If the ESOPhas an outstan	ding exempt loan with the employer as lender, is such loan part of a *	back-to-bac	 k" loan?	☐ Yes	☐ No ☐ No		
(See instructions for definit	lion of "back-to-back" loan.)	••••	<u> </u>	<u></u>			
	hat is not readily tradable on an established securities market?	<u></u>		Yes	No 5500) 2011		

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Par		Additional Information for Multiemployer Defined Benefit Pension Plans										
13	Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.											
	a	Name of contributing employer										
1	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 Day Year										
	9	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) Contribution rate (in dollars and cents) (2) Base unit measure: Hourty Weekly Unit of production Other (specify):										
	a											
	 b	EIN C Dollar amount contributed by employer										
	<u>d</u>	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										
	e	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) Contribution rate (in dollars and cents) (2) Base unit measure: Hourty Weekly Unit of production Other (specify):										
	a	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										
(9	Contribution rate information (<i>if more than one rate applies</i> , check this box 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):										
i	a	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										
	8	Contribution rate information (<i>if more than one rate applies, check this box</i> and <i>see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).</i>) (1) Contribution rate (in dollars and cents) (2) Base unit measure: Hourly Weekly Unit of production Other (specify):										
	a	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										
	6	Contribution rate information (<i>if more than one rate applies, check this box</i> and see instructions regarding required attachment. Otherwise, <i>complete items 13e(1) and 13e(2).</i>) (1) Contribution rate (in dollars and cents) (2) Base unit measure: Hourly Weekly Unit of production Other (specify):										
	a	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										
	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):										

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14	Enter the number of participants on whose behalf no contributions 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 make a employer contribution during the current plan year to:	in	
	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	16b	
	assessed against such withdrawn employers		
17	supplemental information to be included as an attachment.		
P	art VI Additional Information for Single-Employer and Multiemployer Defined Ben	efit Per	ision Plans
18		n part) of li	abilities to such participants
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

A	Name of filer, plan administrator, or plan sponsor (see instructions)	в				• -			structions)			
	AURORA HOSPITALIST, PC				Employer identification number (EIN)								
	Number, street, and room or suite no. (If a P.O. box, see instructions)				30516					<u> </u>			
	4201 N. BUFFALO ROAD City or town, state, and ZIP code	1	S	ioci	al secu	nty numb	er (SSN) (see i	nstruction	5)			
c	ORCHARD PARK NY 14127	┠──	P	la		1	Pla	n vea	r ending]			
C	Plan name	1	-)er	N	IM	1	DD	YYYYY			
		1	1		1	-							
	1 AURORA HOSPITALIST, PC 401(K)/PROFIT SHARING PLAN	0	1	0	1	1	2	31	:	2011			
			I		I								
	2	<u> </u>	<u> </u>		<u> </u>			_					
	2				1								
	3	1											
Pa	t II Extension of Time To File Form 5500 Series, and/or Form 8955-	5SA											
					-								
1	I request an extension of time until10 / 15 / to file Form &	500 s	seri	es	(see in	struction	IS).						
•	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-SSA (see instructions).												
	Note. A signature IS required if you are requesting an extension to file Form 8955-SSA.												
	The application is automatically approved to the date shown on line 1 and/or line 2 (a	hove)	if	(a)	the Fo	rm 5558	is filed		before				
	the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extensi	on is r	req	ues	sted, a	nd (b) th	e date	on line	1				
	and/or line 2 (above) is not later than the 15th day of the third month after the normal du	ie dat	e.										
_						*							
Par	Extension of Time To File Form 5330 (see instructions)												
<u> </u>													
3	I request an extension of time until to file Form \$				_								
	You may be approved for up to a 6 month extension to file Form 5330, after the normal	due da	ate	of	Form	5330.							
		►	I	а	1								
a	Enter the Code section(s) imposing the tax	-	L	a									
b	Enter the payment amount attached						►	Ь					
с	For excise taxes under section 4980 or 4980F of the Code, enter the revision/amendme	nt dat	le		•••	• •	►	c					
4	State In detail why you need the extension:												
				-				<u>.</u>					
							_						
			_										
					-								
	r penaities of perjury, I declare that to the best of my knowledge and belief, the statements made on I	his for	m é	are	true. co	rrect, and	comple	te, and	I that I am	authorized			