Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN

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SIGN HERE

Annual Return/Report of Employee Benefit Plan

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 sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2011

This Form is Open to Public

| | | | | | inspection | |
|-----------------|-----------------------------------|---|---|---------------------------------|--|------|
| Part I | Annual Report Ide | ntification Information | | | | |
| For caler | ndar plan year 2011 or fiscal | plan year beginning 01/01/2011 | | and ending 12/31/20 |)11 | |
| A This r | eturn/report is for: | a multiemployer plan; | a multiple | e-employer plan; or | | |
| | · | a single-employer plan; | a DFE (sp | pecify) | | |
| | | | _ | | | |
| B This r | eturn/report is: | the first return/report; | the final re | eturn/report; | | |
| | | x an amended return/report; | a short pla | an year return/report (less tha | an 12 months). | |
| C If the | plan is a collectively-bargair | ned plan, check here | | | ▶ | |
| D Check | k box if filing under: | X Form 5558; | automatio | extension; | the DFVC program; | |
| | - | special extension (enter desc | cription) | | _ | |
| Part I | I Basic Plan Infor | mation—enter all requested informa | ition | | | |
| 1a Nam | | · | | | 1b Three-digit plan | 001 |
| ENDION | HOSPITALIST NORTH, PO | C 401(K)/PROFIT SHARING PLAN | | | number (PN) ▶ | |
| | | | | | 1c Effective date of pla 01/01/2009 | ın |
| 2a Plan | sponsor's name and addre | ss, including room or suite number (En | nployer, if for single- | employer plan) | 2b Employer Identifica | tion |
| | | | | | Number (EIN) | |
| ENDION | HOSPITALIST NORTH, PO | | | | 20-5902113 | |
| | | | | | 2c Sponsor's telephon number | е |
| | | | | | 716-662-2544 | |
| | BUFFALO ROAD RD PARK, NY 14127 | | UFFALO ROAD D PARK, NY 14127 | | 2d Business code (see |) |
| | , | | - · · · · · · · · · · · · · · · · · · · | | instructions) | |
| | | | | | 621111 | |
| | | | | | | |
| | | | | | | |
| Caution: | A penalty for the late or i | ncomplete filing of this return/repor | t will be assessed ι | inless reasonable cause is | established. | |
| | | penalties set forth in the instructions, I as the electronic version of this return | | | | |
| | | | | | | |
| SIGN HERE | Filed with authorized/valid e | lectronic signature. | 10/02/2012 | JOHN A BRACH MD | | |
| TILKE | Signature of plan admini | strator | Date | Enter name of individual sig | ning as plan administrator | |

10/02/2012

Date

Date

JOHN A BRACH MD

Enter name of individual signing as employer or plan sponsor

Signature of DFE Enter name of individual signing as DFE For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Form 5500 (2011) v.012611

Form 5500 (2011) Page **2**

| | Plan administrator's name and address (if same as plan sponsor, enter "San DION HOSPITALIST NORTH, PC | ne") | | | ministrator's EIN -5902113 |
|---------|--|----------------------|--|----------|---|
| | 01 N. BUFFALO ROAD CHARD PARK, NY 14127 | | | | ministrator's telephone mber 716-662-2544 |
| 4 a | If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report: Sponsor's name | n/report filed for t | his plan, enter the name, EIN | and | 4b EIN 4c PN |
| | · | | | T | |
| 5 | Total number of participants at the beginning of the plan year | | | 5 | 2 |
| 6 | Number of participants as of the end of the plan year (welfare plans complete | e only lines 6a, 6 | 6b, 6c, and 6d). | | 1 |
| а | Active participants | | | 6a | 2 |
| b | Retired or separated participants receiving benefits | | | 6b | |
| | | | | 60 | |
| C | Other retired or separated participants entitled to future benefits | | | 6c | |
| d | Subtotal. Add lines 6a, 6b, and 6c | | | 6d | 2 |
| е | Deceased participants whose beneficiaries are receiving or are entitled to re | ceive benefits | | 6e | |
| f | Total. Add lines 6d and 6e. | | | 6f | 2 |
| g | Number of participants with account balances as of the end of the plan year complete this item) | | | 6g | 2 |
| h | Number of participants that terminated employment during the plan year with less than 100% vested | | | 6h | |
| 7 | Enter the total number of employers obligated to contribute to the plan (only | multiemployer p | lans complete this item) | 7 | |
| 8a b | If the plan provides pension benefits, enter the applicable pension feature con the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits, enter the applicable welfare feature continued by the plan provides welfare benefits and the plan provides welfare benefits. | | | | |
| 9a | Plan funding arrangement (check all that apply) | 9b Plan bene | efit arrangement (check all tha | t apply) | |
| | (1) Insurance | | Insurance | | |
| | (2) Code section 412(e)(3) insurance contracts (3) Trust | (2) | Code section 412(e)(3) i X Trust | nsurano | e contracts |
| | (4) General assets of the sponsor | (4) | General assets of the sp | onsor | |
| 10 | Check all applicable boxes in 10a and 10b to indicate which schedules are a | | nere indicated, enter the numb | er attac | hed. (See instructions) |
| а | Pension Schedules | b General | Schedules | | |
| | (1) R (Retirement Plan Information) | (1) | H (Financial Inform | nation) | |
| | (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | (2) (3) (4) | I (Financial Inform A (Insurance Inform C (Service Provide | mation) | , |
| | (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | (5) (6) | D (DFE/Participation G (Financial Trans | ng Plan | Information) |
| | | | | | |

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2011

| r ension benefit duaranty oc | riporation | | s are required to provide to ERISA section 103(a)(2) | | tion | This Fo | rm is Open to Public Inspection |
|---|------------------|--|--|-----------------------|--------------------------|--------------|------------------------------------|
| For calendar plan year 20 | 11 or fiscal pla | an year beginning 01/01/2011 | | and en | nding 12/3 | 1/2011 | |
| A Name of plan ENDION HOSPITALIST N | NORTH, PC 4 | 01(K)/PROFIT SHARING PLAN | | | e-digit number (PN) | • | 001 |
| C Plan sponsor's name a | | ne 2a of Form 5500 | | D Emplo 20-590 | oyer Identifica 02113 | tion Number | (EIN) |
| | | ning Insurance Contract . Individual contracts grouped a | | | | | |
| (a) Name of insurance ca | | | | | | | |
| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate n persons covered a | it end of | (f) i | Policy or c | ontract year (g) To |
| 31-4156830 | 66869 | 0000ENDI00NY00K | policy or contract | t year 2 | 01/01/201 | | 12/31/2011 |
| 2 Insurance fee and com descending order of the | | | otal commissions paid. L | ist in item 3 | I 3 the agents, I | orokers, and | other persons in |
| | | nmissions paid | | (b) To | otal amount o | f fees paid | |
| 0 | | 0 | | | | | 0 |
| Persons receiving com | | fees. (Complete as many entries and address of the agent, broke | | | sions or fees w | vere naid | |
| | (1) | | ees and other commissio | | | | I |
| (b) Amount of sales ar commissions pa | | (c) Amount | ees and other commissio | (d) Purpose | e | | (e) Organization code |
| | | (5): | | (4) | <u> </u> | | (5) 0.3 |
| | (a) Name | and address of the agent, broke | r. or other person to who | m commiss | sions or fees v | vere paid | |
| | (4) | | ,, | | | p | |
| (b) Amount of sales ar | nd base | F | ees and other commissio | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | е | | (e) Organization code |
| | | | | | | | |

| Schedule A (Form 5500) | 2011 | Page 2 - 1 |] | |
|---|-------------------------------------|-------------------------------|-------------------------------|-----------------------|
| | ame and address of the agent, broke | r. or other person to whom o | commissions or fees were paid | |
| (4) | and address of the agont, siene | ., c. carer percent to innern | | |
| | | | | |
| | | | | |
| (L) A | | Fees and other commission | s paid | (-) () |
| (b) Amount of sales and base commissions paid | (c) Amount | | (d) Purpose | (e) Organization code |
| • | , , | | | |
| | | | | |
| | | | | |
| (a) Na | ame and address of the agent, broke | r, or other person to whom o | commissions or fees were paid | |
| | | | | |
| | | | | |
| | | | | |
| (b) Amount of sales and base | | Fees and other commission | s paid | (e) Organization |
| commissions paid | (c) Amount | | (d) Purpose | code |
| | | | | |
| | | | | |
| | | | | |
| (a) Na | ame and address of the agent, broke | r, or other person to whom o | commissions or fees were paid | |
| | | | | |
| | | | | |
| | T | | | T |
| (b) Amount of sales and base | | Fees and other commission | | (e) Organization |
| commissions paid | (c) Amount | | (d) Purpose | code |
| | | | | |
| | | | | |
| (a) Na | ame and address of the agent, broke | r or other person to whom o | commissions or fees were paid | |
| (a) (ve | and address of the agent, broke | r, or other person to whom t | commissions of fees were paid | |
| | | | | |
| | | | | |
| | I | | | |
| (b) Amount of sales and base commissions paid | (c) Amount | Fees and other commission | s paid (d) Purpose | (e) Organization |
| commissions paid | (c) Amount | | (d) Fulpose | code |
| | | | | |
| | | | | |
| (a) Na | ame and address of the agent, broke | r, or other person to whom o | commissions or fees were paid | |
| | | , , | • | |
| | | | | |
| | | | | |
| | | Fees and other commission | s naid | T., |
| (b) Amount of sales and base commissions paid | (c) Amount | 1 003 and other commission | (d) Purpose | (e) Organization code |
| Commissions paid | (o) / anount | | (±). 3.5000 | |
| | | | | |
| | | | | 1 |

| | | • |
|-----|---|-----|
| חבי | Δ | - 5 |
| ay | | • |

| P | art II | Investment and Annuity Contract Information | | | | |
|---|--------|--|---------------|--------------------------|--------------------|----------------------|
| | | Where individual contracts are provided, the entire group of such indivithis report. | idual contrac | its with each carrier ma | ay be treated as a | unit for purposes of |
| 4 | Curre | ent value of plan's interest under this contract in the general account at year | end | | 4 | 0 |
| | | ent value of plan's interest under this contract in separate accounts at year en | | | 5 | 62777 |
| _ | Contr | racts With Allocated Funds: | | | | |
| | а | State the basis of premium rates NOT PROVIDED BY INSURANCE CO |). | | | |
| | | | | | | |
| | b | Premiums paid to carrier | | | 6b | 3232 |
| | C | Premiums due but unpaid at the end of the year | | | 6с | |
| | | If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount | | | 6d | 129 |
| | | Specify nature of costs CONTRACT COMMISSIONS | | | | |
| | | -, -, | | | | |
| | е | Type of contract: (1) ☑ individual policies (2) ☐ group deferred | d annuity | | | |
| | | (3) other (specify) | | | | |
| | | | | | | |
| | f | If contract purchased, in whole or in part, to distribute benefits from a termin | ating plan ch | neck here | | |
| 7 | Contr | acts With Unallocated Funds (Do not include portions of these contracts ma | intained in s | eparate accounts) | | |
| | | | | on guarantee | | |
| | | (3) ☐ guaranteed investment (4) ☐ other ▶ | | | | |
| | | (e) [] gastamood intodinion | | | | |
| | | | | | | |
| | b | Balance at the end of the previous year | | | 7b | |
| | | Additions: (1) Contributions deposited during the year | _ // | | 1 | |
| | | (2) Dividends and credits | 7c(2) | | | |
| | | (3) Interest credited during the year | 7c(3) | | | |
| | | (4) Transferred from separate account | 7c(4) | | | |
| | | (5) Other (specify below) | 7c(5) | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | (6)Total additions | | | 7c(6) | |
| | | Total of balance and additions (add b and c(6)). | | | 7d | |
| | | 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) | | | |
| | ĺ | • | | | | |
| | | | | | | |
| | | | | | | |
| | 1 | (5) Total deductions | | | 7e(5) | |
| | , | Balance at the end of the current year (subtract e(5) from d) | | | | |

| | Schedule A (Form 5500) 2011 | | Page 4 | | |
|-----|--|--|-------------------|-----------------------------|-------------------------|
| I | Welfare Benefit Contract Information If more than one contract covers the same groen information may be combined for reporting pure the entire group of such individual contracts with | oup of employees of the sarposes if such contracts are | e experience-rate | d as a unit. Where contract | |
| efi | it and contract type (check all applicable boxes) | | | | |
| 1 | Health (other than dental or vision) | b Dental | c Visio | n | d Life insurance |
| | Temporary disability (accident and sickness) | f Long-term disability | g Supp | elemental unemployment | h Prescription drug |
| Ī | Stop loss (large deductible) | j HMO contract | k ☐ PPO | contract | I Indemnity contract |
| Ī | Other (specify) | _ | _ | | |
| eri | ence-rated contracts: | | | | |
| Pr | remiums: (1) Amount received | | 9a(1) | | |
| (2 | 2) Increase (decrease) in amount due but unpaid. | | 9a(2) | | |
| (3 | 3) Increase (decrease) in unearned premium rese | rve | 9a(3) | | |
| (4 | 4) Earned ((1) + (2) - (3)) | <u></u> | | 9a(4) | |
| В | Benefit charges (1) Claims paid | | 9b(1) | | |
| (2 | 2) Increase (decrease) in claim reserves | | 9b(2) | | |
| (3 | 3) Incurred claims (add (1) and (2)) | | | 9b(3) | |

9b(4)

10a

10b

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions 9c(1)(A) (B) Administrative service or other fees 9c(1)(B) 9c(1)(C) (C) Other specific acquisition costs..... (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... (F) Charges for risks or other contingencies 9c(1)(F) (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement...... 9d(1) (2) Claim reserves 9d(2) 9d(3) (3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e

| Part IV | Provision of Information | | | |
|------------------|--|-----|----|--|
| 11 Did tl | ne insurance company fail to provide any information necessary to complete Schedule A? | Yes | No | |

a Health (other than dental or vision)

Experience-rated contracts:

10 Nonexperience-rated contracts:

Specify nature of costs

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid......

(4) Claims charged.....

Total premiums or subscription charges paid to carrier 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.....

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

SCHEDULE I (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Financial Information—Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2011

This Form is Open to Public Inspection

| For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 | and ending 12/31/2011 |
|---|--|
| A Name of plan ENDION HOSPITALIST NORTH, PC 401(K)/PROFIT SHARING PLAN | B Three-digit plan number (PN) 001 |
| | |
| C Plan sponsor's name as shown on line 2a of Form 5500 | D Employer Identification Number (EIN) |
| ENDION HOSPITALIST NORTH, PC | 20-5902113 |
| Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plasmall plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting a | |
| Part I Small Plan Financial Information | |

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

| 1 | Plan Assets and Liabilities: | | (a) Beginning of Year | (b) End of Year |
|---|--|---------|-----------------------|------------------|
| а | Total plan assets | . 1a | 66285 | 69659 |
| b | Total plan liabilities | . 1b | 0 | 0 |
| С | Net plan assets (subtract line 1b from line 1a) | 1c | 66285 | 69659 |
| 2 | Income, Expenses, and Transfers for this Plan Year: | | (a) Amount | (b) Total |
| а | Contributions received or receivable: | | | |
| | (1) Employers | . 2a(1) | 0 | |
| | (2) Participants | . 2a(2) | 2481 | |
| | (3) Others (including rollovers) | . 2a(3) | | |
| b | Noncash contributions | . 2b | | |
| С | Other income | . 2c | 935 | |
| d | Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) | . 2d | | 3416 |
| е | Benefits paid (including direct rollovers) | . 2e | | |
| f | Corrective distributions (see instructions) | . 2f | | |
| g | Certain deemed distributions of participant loans (see instructions) | . 2g | | |
| h | Administrative service providers (salaries, fees, and commissions) | . 2h | 42 | |
| i | Other expenses | . 2i | | |
| j | Total expenses (add lines 2e, 2f, 2g, 2h, and 2i) | . 2j | | 42 |
| k | Net income (loss) (subtract line 2j from line 2d) | . 2k | | 3374 |
| | Transfers to (from) the plan (see instructions) | . 2I | | |

Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a lineby-line basis unless the trust meets one of the specific exceptions described in the instructions.

| | _ | | Yes | No | Amount |
|---|---|----|-----|----|--------|
| а | Partnership/joint venture interests | 3a | | X | |
| b | Employer real property | 3b | | X | |
| С | Real estate (other than employer real property) | 3с | | X | |
| d | Employer securities | 3d | | X | |
| | Participant loans | 3e | | X | |

| Page 2 - |
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Schedule I (Form 5500) 2011

| | | Г | | | I | | |
|----|---|----------|---------|-----------|--------------|---------------|--------------------|
| | , | | Yes | No | | Amount | |
| 3f | Loans (other than to participants) | 3f | | X | | | |
| g | Tangible personal property | 3g | | X | | | |
| | · | -3 | | L | | | |
| D- | urt II Compliance Overtions | | | | | | |
| | art II Compliance Questions | | l | T | T | | |
| 4 | During the plan year: | | Yes | No | | Amount | |
| а | Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) | 4a | | X | | | |
| b | Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance | 4b | | X | | | |
| С | Were any leases to which the plan was a party in default or classified during the year as uncollectible? | 4c | | X | | | |
| d | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.) | 4d | | X | | | |
| е | Was the plan covered by a fidelity bond? | 4e | X | | | | 6000 |
| f | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | 4f | | X | | | |
| g | Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? | 4g | | X | | | |
| h | Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? | 4h | | X | | | |
| i | Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest? | 4i | | X | | | |
| j | Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | 4j | | X | | | |
| k | Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.) | 4k | X | | | | |
| 1 | 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 | | | | |
| 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 | | | | |
| 5a | Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year | Ye | s X | lo / | Amount: | | |
| 5b | If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.) | entify t | he plar | n(s) to v | vhich assets | or liabilitie | es were |
| | 5b(1) Name of plan(s) | | | 5b(2 |) EIN(s) | | 5b(3) PN(s) |
| | | | | | | | |
| | | | | | | | |
| | | | | | | + | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

5500 Electronic Filing Authorization

Plan Name: Er

Endion Hospitalist North, PC 401(k)/Profit Sharing Plan

EIN/PN:

20-5902113/001

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 Administrator

(sign)

10-2-12

(date)

Plan Spons

(sign)

10-2-12

(date)

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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 sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2011

This Form is Open to Public Inspection

| Part I | Annual Report | Identification Information | | | | | |
|---------------------|--|---|---|---|--|--|--|
| For the c | alendar plan year 201 | 1 or fiscal plan year beginning | 01/01/2011 | and ending 12/31 | /2011 | | |
| A This re | tum/report is for: | a multiemployer plan; | | a multiple-employer p | tan; or | | |
| | | X a single-employer plan; | | a DFE (specify) | | | |
| | | | | | | | |
| B This re | turn/report is: | the first return/report; | | the final return/report; | | | |
| | | an amended return/report; | | a short plan year retu | rn/report (less than 12 months). | | |
| C If the p | olan is a collectively-bar | gained plan, check here | | <u>.</u> | ▶□ | | |
| D Check | box if filing under: | X Form 5558; | | automatic extension; | the DFVC program; | | |
| | | special extension (enter description | on) | | | | |
| Part II | Basic Plan Info | ermation enter all requested in | formation. | | | | |
| | ne of plan | | | | 1b Three-digit plan | | |
| | * · · · · · · · · · · · · · · · · · · · | North, PC 401(k)/Profit S | haring Plan | | number (PN) ▶ 001 | | |
| | • | • | - | | 1C Effective date of plan | | |
| | | | | | 01/01/2009 | | |
| 2a Pla | n sponsor's name and a | ddress, including room or suite number | r (Employer, if for sing | le-employer plan) | 2b Employer Identification Number (EIN) | | |
| | | Name DO | | | 20-5902113 | | |
| End | ion Hospitalist | North, PC | | | 2c Sponsor's telephone | | |
| | | | | | number | | |
| | | | | | (716) 662-2544 | | |
| 420 |)1 N. Buffalo Ro | ad | | | 2d Business code (see | | |
| | | | | | instructions) | | |
| US | Orchard Park | NY 14127 | | | 621111 | | |
| | | | | | | | |
| | | | | ·· | <u> </u> | | |
| | | r incomplete filing of this return/repo | | | | | |
| Under per statement | nalties of perjury and oth s and attachments, asy | ner penalties set forth in the instructions well as the electronic version of this retu | i, I declare that I have im/report, and to the I | examined this return/report, it best of my knowledge and bel | ncluding accompanying schedules, ief, it is true, correct, and complete. | | |
| | | | | | | | |
| SIGN | (JKI | War ' | 10-2-12 | John A. Brach, MD | i | | |
| HEILE | Signature of plan ac | intinistrator | Date | Enter name of individual sig | ning as plan administrator | | |
| | I AL | | | | | | |
| SIGN | 1 / 10Ki | (A)tic | 10-2-12 | John A. Brach, MD | | | |
| | Signature of employ | ver/plan sponsor | Date | Enter name of individual sig | ning as employer or plan sponsor | | |
| SIGN | | | | | | | |
| neke | Signature of DFE | | Date | Enter name of individual sig | ning as DFE | | |
| | 1 2 | | | | - | | |

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

Form 5500 (2011) v.012611

| _ | Form 5500 (2011) | | , | | Page 2 | | |
|----|--|-----------|------------|------|--|----------|---------------------------------------|
| 3a | Plan administrator's name and address (if same as plan sponsor, enter "Sa Same | me") | | | Pd 100 | 3b / | Administrator's EIN |
| | | | | | | | Administrator's telephone number |
| | | | | | | | |
| 4 | If the name and/or EIN of the plan sponsor has changed since the last return/report the plan number from the last return/report: | t filed f | or this | pla | in, enter the name, EIN and | I | 4b EIN |
| а | Sponsor's name | | | | | | 4c PN |
| 5 | Total number of participants at the beginning of the plan year | | | | | 5 | 2 |
| 6 | Number of participants as of the end of the plan year (welfare plans comple | te only | lines | 6a | , 6b, 6c, and 6d). | | · · · · · · · · · · · · · · · · · · · |
| а | Active participants | | | | | 6a | 2 |
| 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 | 2 |
| е | Deceased participants whose beneficiaries are receiving or are entitled to re | eceive | benef | lits | | 6e | |
| f | Total. Add lines 6d and 6e | | | | | 6f | 2 |
| g | Number of participants with account balances as of the end of the plan year complete this item) | | | | | 6g | 2 |
| h | Number of participants that terminated employment during the plan year will less than 100% vested | | | | | 6h | |
| 7_ | Enter the total number of employers obligated to contribute to the plan (only | | | | | 7 | |
| | If the plan provides pension benefits, enter the applicable pension feature 2E 2H 2J 2K 3D 3H If the plan provides welfare benefits, enter the applicable welfare feature of | odes fr | om th | ie L | ist of Plan Characteristic Code | s in the | e instructions: |
| 9a | | 9b | | _ | enefit arrangement (check all the | at appl | (y) |
| | (1) X Insurance | | (1) (2) | × | Insurance Code section 412(e)(3) insura | nce co | intracte |
| | (2) Code section 412(e)(3) insurance contracts (3) X Trust | | (3) | × | 1 | | in dots |
| | (4) General assets of the sponsor | | (4) | П | General assets of the sponsor | r | |
| 10 | Check all applicable boxes in 10a and 10b to indicate which schedules are attach | ed, and | i, whe | re i | | | e instructions) |
| а | Pension Schedules | b | Gen | ora | al Schedules | | |
| _ | (1) R (Retirement Plan Information) | | (1) | | H (Financial Informa | ation) | |
| | (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | | (2) (3) | X | I (Financial Informa | nation) | · |
| | | | (4) (5) | Н | C (Service Provider D (DFE/Participatin | | |
| | (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | | (5) (6) | Ц | G (Financial Transa | - | · · |

Sponsor Location Information

Sponsor name:

Endion Hospitalist North, PC

Sponsor DBA name: Sponsor care of name:

4201 N. Buffalo Road

US Orchard Park

NY 14127

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under sections 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

► File as an attachment to Form 5500.

OMB No. 1210-0110

2011

► Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

This Form is Open to Public Inspection.

| For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 | | | | | and ending 12/31/2011 | | | | | |
|--|---------------|---|----------------------------|---------------------------|---|--------------------------|-----------------------|--|--|--|
| A Name of plan | | | | | git nber (PN) | | 001 | | | |
| endion Koonitalist l | North BC | 401(k)/Profit Sharis | ng Plan | | | | 001 | | | |
| modon nospicatise | MOIGI, FC | 401(k)/libile bhall | | | | | | | | |
| C Plan sponsor's name a | s shown on li | ne 2a of Form 5500. | | D Employe | r Indentification I | Number (E | IN) | | | |
| ndion Hospitalist 1 | North, PC | | | | 20-59021: | 13 | | | | |
| Part I Information | Concernir | ng Insurance Contract C ndividual contracts grouped as | overage, Fees, and and III | d Commis can be report | s ions Provide i ed on a single S | nformation chedule A. | for each contract | | | |
| 1 Coverage Information: | | | | | | | | | | |
| (a) Name of insurance cam | ier | | | | | | | | | |
| ATIONWIDE LIFE INS | | | | | | | | | | |
| | | ······································ | (e) Approximate | number of | | Policy or | contract year | | | |
| (b) EIN | (c) NAIC code | (d) Contract or identification number | persons covered | | (f) From | | (g) To | | | |
| 31-4156830 | 66869 | 0000END100NY00K | policy or contr | 2 | 1/1/2011 | | 12/31/2011 | | | |
| | | | 44-4-4 | | | | ather seems in | | | |
| Insurance fee and com descending order of the | | mation. Enter the total fees and d. | o totai commissions pai | o. List in item | o the agents, bit | ikers, and | outer persons in | | | |
| | | mmissions paid | | (b) Tota | Il amount of fees | paid | | | | |
| | | 0 | | | | 0 | | | | |
| 3 Persons receiving com | missions and | l 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 who | om commissi | ons or fees were | paid | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| (b) Amount of sales a | nd base | Fe | es and other commissi | ons paid | | | | | | |
| commissions pa | | (C) Amount | | (d) Purpose | | | (e) Organization code | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| ************************************** | (a) Name a | nd address of the agent, broke | r or other person to who | om commissi | ons or fees were | paid | | | | |
| | (a) Name a | nu audiess of the agent, broke | i, or dater person to win | OII | 5115 51 1005 11010 | pula | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| (h) A | -45 | Fe | ees and other commissi | ons paid | | | | | | |
| (b) Amount of sales a commissions pa | | (C) Amount | | (d) Purpose | | | (e) Organization code | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | I . | | | | | | I | | | |

| Schedule A (Form 5500) | 2011 | Page 2- | <u>.</u> |
|---|-----------------------------|--|-----------------------|
| (a) Name | and address of the agent, b | roker or other person to whom commissions or fees we | re 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, b | roker or other person to whom commissions or fees we | re paid |
| | | | |
| | | | |
| (b) Amount of sales and base | | Fees and other commissions paid | |
| commissions paid | (c) Amount | (d) Purpose | (e) Organization cod |
| | | | |
| | | | |
| (a) Name | and address of the agent, b | roker or other person to whom commissions or fees we | re paid |
| | | | |
| | | | |
| | | Fees and other commissions paid | |
| (b) Amount of sales and base | | (2) 2 | |
| commissions paid | (c) Amount | (d) Purpose | (e) Organization co |
| | | | |
| | | | |
| (a) Name | and address of the agent, b | roker or other person to whom commissions or fees we | re paid |
| | | | |
| | | | |
| (b) Amount of sales and base | | Fees and other commissions paid | |
| commissions paid | (c) Amount | (d) Purpose | (e) Organization cod |
| | | | |
| | | | |
| (a) Name | and address of the agent h | roker or other person to whom commissions or fees we | re paid |
| (a) Name | and address of the agorn, o | ionici ci cina poscinio micro commissioni di cina | |
| | | | |
| | | Fees and other commissions paid | |
| (b) Amount of sales and base commissions paid | (c) Amount | (d) Purpose | (e) Organization cod |
| супппазіона раіц | Tot survey | | |
| | | | |
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|---|--|
| | |
| | |

| Pa | Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such ind | ividual contracts with each carrier n | nav he treate | d as a unit for num | nees of |
|----|---|---------------------------------------|---------------|-----------------------|---------|
| | this report. | indua contracts with cach camer in | nay be acate | a as a dilit for purp | J3C3 U1 |
| 4 | Current value of plan's interest under this contract in the general account at yes | ar end | 4 | | 0 |
| 5 | Current value of plan's interest under this contract in separate accounts at year | | 5 | | 62,777 |
| 6 | Contracts With Allocated Funds: a State the basis of premium rates | | | | |
| | NOT PROVIDED BY INSURANCE CO. | | | | |
| | b Premiums paid to carrier | | 6b | | 3,232 |
| | C Premiums due but unpaid at the end of the year | | 6c | <u> </u> | |
| | d If the carrier, service, or other organization incurred any specific costs in coor retention of the contract or policy, enter amount | nnection with the acquisition | 6d | | 129 |
| | Specify nature of costs ► | | | | |
| | CONTRACT COMMISSIONS | | | | |
| | e Type of contract (1) x individual policies (2) group deferred a | nnuity | | | |
| | (3) ☐ other (specify) ► | | | | |
| | | | | | |
| | f 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 | | <u> </u> | | |
| • | a Type on contract (1) ☐ deposit administration (2) ☐ | immediate participation guarantee | | | |
| ٠ | - · · · · · · · · · · · · · · · · · · · | other ► | | | |
| | (5) U guaranteed investment | | | | |
| | | | | | |
| | | | | | |
| ı | Balance at the end of the previous year | <u> </u> | 7b | | |
| (| C Additions: (1) Contributions deposited during the year | 7c(1) | | <u> </u> | |
| | (2) Dividends and credits | 7c(2) | | } | |
| | (3) Interest credited during the year | 7c(3) | | 1 | *** |
| | (4) Transferred from separate account | 7c(4) | | | |
| | (5) Other (specify below) | 7c(5) | | | |
| | • | | į | | |
| | | A Section 1 | | | |
| | | | | | |
| | (6) Total additions | | 7c(6) | | |
| | d Total of balance and additions (add b and c(6)) | | 7d | | |
| | Deductions: | | 1.7 | | |
| • | (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) | | <u>'</u> | |
| | (4) Other (specify below) | 7e(4) | |] | ٠. |
| | > | | | | |
| | | 10 pg | | | - |
| | | | | | , Più |
| | | | 70/51 | | |
| _ | (5) Total deductions | | 7e(5) | | |
| | Balance at the end of the current year (subtract e(5) from d) | | 7f | <u> </u> | _ |

| Р | an | A | 4 |
|---|----|---|---|
| | | | |

| Par | Welfare Benefit Contract Informa | ıtion | | | |
|-----|---|---------------------------------------|-------------------------------|----------------|--|
| | If more than one contract covers the same gro information may be combined for reporting put the entire group of such individual contracts w | rposes if such contracts are exp | perience-rated as a unit. Who | ere contracts | |
| 8 | Benefit and contract type (check all applicable boxes) | | | | |
| | a U Health (other than dental or vision) | b Dental | C U Vision | | d Life insurance |
| | e Temporary disability (accident and sickness) | f Long-term disability | g Supplemental unem | ployment | h Prescription drug |
| | i Stop loss (large deductible) | j HMO contract | k PPO contract | | I Indemnity contract |
| | m Other (specify) ▶ | | _ | | |
| | | | | | |
| 9 | Experience-rated contracts: | | | | |
| а | Premiums: (1) Amount received | | 9a(1) | | - |
| | (2) Increase (decrease) in amount due but unpaid | | 9a(2) | | 4 |
| | (3) Increase (decrease) in unearned premium reser | | 9a(3) | 0.(4) | |
| 1. | | | 05/4 | 9a(4) | |
| b | Benefit charges: (1) Claims paid | | 9b(1) | | - · · · · · · · · · · · · · · · · · · · |
| | (-, | | 9b(2) | 0h/2\ | |
| | (3) Incurred claims (add (1) and (2)) | | | 9b(3) 9b(4) | |
| С | (4) Claims charged | · · · · · · · · · · · · · · · · · · · | • • • • • • • • • • | 30(4) | |
| C | (A) Commissions | | 9c(1)(A) | | ┪ . |
| | (B) Administrative service or other fees | | 9c(1)(B) | | † |
| | (C) Other specific acquisition costs | | 9c(1)(C) | | 1 |
| | (D) Other expenses | | 9c(1)(D) | | † |
| | (E) Taxes | | 9c(1)(E) | | 1 |
| | (F) Charges for risks or other contingencies | | 9c(1)(F) | | 1 |
| | (G) Other retention charges | | 9c(1)(G) | | |
| | (H) Total retention | <u>.</u> | | 9c(1)(H) | |
| | (2) Dividends or retroactive rate refunds. (The amo | unts were 🔲 paid in cash, | or credited.) | 9c(2) | |
| d | Status of policyholder reserves at end of year: (1) A | mount held to provide benefits | after retirement | 9d(1) | |
| | (2) Claim reserves | | | 9d(2) | |
| | (3) Other reserves | | | 9c(3) | |
| е | Dividends or retroactive rate refunds due. (Do not inc | clude amount entered in c(2).) | | 9e | |
| 10 | Nonexperience-rated contracts: | | | | |
| а | Total premiums or subscription charges paid to carrie | | | 10a | |
| b | If the carrier, service, or other organization incurred a | | | 406 | |
| | retention of the contract or policy, other than reported | I in Part I, item 2 above, report | amount | 10b | |
| Spe | ecify nature of costs > | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |
| Par | IV Provision of Information | | | | |

11 Did the insurance company fail to provide any information necessary to complete Schedule A? . . .

SCHEDULE I (Form 5500)

Department of the Treasury

Financial Information - Small Plan

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

OMB No. 1210-0110 2011

| | Internal Revenue Service | | internal Revenu | ie code (me c | ,00e). | | ı | | | |
|-----------------|--|---|----------------------------|------------------|----------------|---|-------------|---|----------------------|--|
| E | Department of Labor mployee Benefits Security Administration | • | File as an attach | ment to For | m 5500. | | | | rm is Open to Public | |
| | Pension Benefit Guaranty Corporation | <u> </u> | | | | | | | Inspection. | |
| For | calendar plan year 2011 or fiscal plan | year beginning | 01/01/2011 | | and endi | | 1/2011 | | | |
| A | Name of plan | | | | | B Thre | e-digit | | | |
| | Endion Hospitalist North, | PC 401(k)/Pr | ofit Sharing P | Plan | | plan | number (| PN) ▶ | 001 | |
| | | | | | | | | | | |
| C | Plan sponsor's name as shown on lin | e 2a of Form 5500 | | | | D Emp | lover iden | tification Nu | ımber (EIN) | |
| | Endion Hospitalist North, | | | | | | 5902113 | | , | |
| Comp | elete Schedule I if the plan covered few | | ants as of the beginn | ning of the plan | vear. You | | | | vou are filing as a | |
| | plan under the 80-120 participant rule | | | | | | p | | you are iming as a | |
| P | artii Small Plan Financial | Information | | | - | | | | | |
| asset: benef | It below the current value of assets an s held in more than one trust. Do not e it at a future date. Include all income a ince carriers. Round off amounts to t | enter the value of the and expenses of the | e portion of an insurar | nce contract th | nat guarante | es during t | his plan ye | ear to pay a | specific dollar | |
| 1 | Plan Assets and Liabilities: | · · · · · · · · · · · · · · · · · · | | | (a) Begin | ning of Yea | r | (b) End of Year | | |
| а | Total plan assets | | | . 1a | | (| 6,285 | | 69,659 | |
| b | Total plan liabilities | | | . 1b | | | 0 | | (| |
| C | Net plan assets (subtract line 1b from | n line 1a) | | . 1c | | (| 6,285 | | 69,659 | |
| 2 | Income, Expenses, and Transfe | | | | (a) An | | | (b) T | | |
| а | Contributions received or receivable | | | | | | | | | |
| | (1) Employers | | | . 2a(1) | | | 0 | | | |
| | | | | | | | 2,481 | | | |
| | (3) Others (including rollovers) | | | | | | | | 4 | |
| ь | Noncash contributions | | | | | | | | | |
| C | Other income | | | | | | 935 | | | |
| d | Total income (add lines 2a(1), 2a(2), | | | | | | | | 3,416 | |
| e | Benefits paid (including direct rollove | | | | | | | | | |
| f | Corrective distributions (see instructi | • | | | t | | | 7 | | |
| g | Certain deemed distributions of parti | | | | | | | | | |
| 9 | (see instructions) | • | | . 2g | 1 | | | | | |
| h | · · · · · · · · · · · · · · · · · · · | | | | | | 42 | | | |
| i | • | | | | | | | 100000 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | | |
| i | Total expenses (add lines 2e, 2f, 2g, | | | | | | 1. (E. S.) | | 42 | |
| k | Net income (loss) (subtract line 2j fro | | | | 1 | | | | 3,374 | |
| î | Transfers to (from) the plan (see inst | | | | j | u tere er i tilbal. Halling i tilbal | | | | |
| <u>.</u> | Specific Assets: If the plan held asset | | | | ories, check | "Yes" and er | ter the cur | rent value of | any assets | |
| 3 | remaining in the plan as of the end of the by-line basis unless the trust meets one of | plan year. Allocate the | e value of the plan's inte | erest in a comm | ingled trust o | ontaining the | assets of | nore than on | e plan on a line- | |
| | | | | | | Yes | No | Am | ount | |
| а | Partnership/joint venture interests | | | | [3 | 3a | х | | | |
| b | Employer real property | | | | | 3b | x | | | |
| | Real estate (other than employer rea | | | | | 3c | x | | | |
| | | | | | | | | | | |

3d

3e

X

x

| | _ | | Yes | No | Aı | nount | |
|--------|--|------------|--------------------------------------|-------------|----------------|--------------------------|--|
| 3f | Loans (other than to participants) | 3f | | х | | | |
| g | Tangible personal property | 3g | | x | L | | |
| 'art l | Compliance Questions | | | | | | |
| 4 | During the plan year: | , | Yes | No | Ar | nount | |
| a | Was there a failure to transmit to the plan any participant contributions within the time period | 1 | | . जिल्हा | 1 | · - | |
| | described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program) | 4a | | x | | ··· · · · · · · · | |
| b | Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance | 4b | | x | 1 | | |
| С | 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 | | | | | | ; - |
| - | | 4d | | x | | | |
| е | Was the plan covered by a fidelity bond? | 4e | х | | | | 6,00 |
| 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, |
| h | Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? | 4h | | x | | | |
| i | Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest? | 4i | | x | | | |
| j | Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | 4 j | 1 1 1 1 1 1 1 1 | 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 | Х | <u> </u> | 12-2-2-2-2-2 | and the same of the same | بر ها المالية |
| 1 | Has the plan failed to provide any benefit when due under the plan? | 41 | | | | | |
| m | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | 4m | X | | | : : :- : | · |
| n | If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of | 4n | x | | | | Property Pro |
| 5a | Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? | | | • | | | , |
| | If "Yes," enter the amount of any plan assets that reverted to the employer this year | X |] No | Amount | t: | | |
| | | | | | | | |
| 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.) | n(s) to | which as | sets or lia | abilities were | | |
| | 5b(1) Name of plan(s) | 5t | (2) | EIN(s) | | 5b(3) | PN(s) |
| | Sw(1) Hamo or prantos | | ·. - / | (0) | | ,-, | |
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Schedule I (Form 5500) 2011

Page 2-

Form 5558 (Rev. June 2011) Department of the Treasury Internal Rovenue Service

Application for Extension of Time To File Certain Employee Plan Returns

OMB No. 1545-0212

File With IRS Only

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

Identification Filer's identifying number (see instructions) Name of filer, plan administrator, or plan sponsor (see instructions) Endion Hospitalist North, PC Employer identification number (EIN) Number, street, and room or suite no. (If a P.O. box, see instructions) 20-5902113 4201 N. Buffalo Road Social security number (SSN) (see instructions) City or town, state, and ZIP code NY 14127 Orchard Park Plan year ending--C Plan Plan name number MM YYYY DD ı Endion Hospitalist North, PC 401(k)/Profit Sharing Plan 0 | 0 11 12 31 2þ11 T Ī Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA I request an extension of time until 10 / 15 / 2012 to file Form 5500 series (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series. to file Form 8955-SSA (see instructions). I request an extension of time until 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 (above) if: (a) the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on line 1 and/or line 2 (above) is not later than the 15th day of the third month after the normal due date. Part III Extension of Time To File Form 5330 (see instructions) I request an extension of time until You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330. Enter the Code section(s) imposing the tax b Enter the payment amount attached For excise taxes under section 4980 or 4980F of the Code, enter the revision/amendment date State in detail why you need the extension:

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