Form 5500	Form 5500         Annual Return/Report of Employee Benefit Plan           Department of the Treasury Internal Revenue Service         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), and 6058(a) of the Internal Revenue Code (the Code).		OMB Nos. 12 12	10-0110 10-0089	
			2009		
Department of Labor Employee Benefits Security Administration	Employee Benefits Security Complete all entries in accordance with		2005		
Pension Benefit Guaranty Corporation			This Form is Open to Pu Inspection	blic	
Part I Annual Report Ider	tification Information				
For calendar plan year 2009 or fiscal	plan year beginning 01/01/2009 and ending	12/31/200	09		
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or	r			
·	a single-employer plan;				
<b>B</b> This return/report is:	the first return/report; the final return/report;				
	X an amended return/report; A short plan year return/rep	ort (less thar	than 12 months).		
<b>C</b> . If the plan is a collectively-bargain	ed plan, check here.		ъП		
<b>D</b> Check box if filing under:	Form 5558; automatic extension;		the DFVC program;		
	special extension (enter description)				
Part II Basic Plan Inform	nation—enter all requested information				
<b>1a</b> Name of plan NIAGARA HOSPITALIST, PC 401(K)	·		<b>1b</b> Three-digit plan number (PN) ►	001	
			1c Effective date of pla 01/01/2006	an	
2a Plan sponsor's name and addres (Address should include room or s NIAGARA HOSPITALIST, PC	s (employer, if for a single-employer plan) uite no.)		2b Employer Identifica Number (EIN) 20-1993782	tion	
			2c Sponsor's telephon number 716-828-2434	e	
4201 N. BUFFALO ROAD ORCHARD PARK, NY 14127	4201 N. BUFFALO ROAD ORCHARD PARK, NY 14127		2d Business code (see instructions) 621111	;	

## Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	12/04/2012	JOHN BRACH MD
HERE		Date	Enter name of individual signing as plan administrator
SIGN	Filed with authorized/valid electronic signature.	12/04/2012	JOHN BRACH MD
HERE		Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

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	Plan administrator's name and address (if same as plan sponsor, enter "Same")	<b>3b</b> Administrator's EIN 20-1993782		
420	D1 N. BUFFALO ROAD CHARD PARK, NY 14127	3c Adi	ministrator's telephone mber 5-828-2434	
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:	and	4b EIN	
а	Sponsor's name		<b>4c</b> pn	
5	Total number of participants at the beginning of the plan year	5	13	
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).			
а	Active participants	6a	14	
b	Retired or separated participants receiving benefits	6b	0	
С	Other retired or separated participants entitled to future benefits	6c	0	
d	Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b>	6d	14	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	0	
f	Total. Add lines <b>6d</b> and <b>6e</b>	6f	14	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	5	
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 3D 3H

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

9a	9a Plan funding arrangement (check all that apply)			<b>9b</b> Plan benefit arrangement (check all that apply)				
	(1)	X	Insurance		(1)	Х	Insurance	
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts	
	(3)	X	Trust		(3)		Trust	
	(4)		General assets of the sponsor		(4)		General assets of the sponsor	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are atta					d, and, w	nere	e indicated, enter the number attached. (See instructions)	
a Pension Schedules								
а	Pensio	on Scl	hedules	b	General	Sch	nedules	
а	Pensio (1)	on Sci	hedules R (Retirement Plan Information)	b	General (1)	Sch	nedules H (Financial Information)	
а		on Scl		b		Sch		
а	(1)	on Scl	<ul> <li>R (Retirement Plan Information)</li> <li>MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan</li> </ul>	b	(1)	Sch ×	H (Financial Information)	
a	(1)	on Scl	<ul><li>R (Retirement Plan Information)</li><li>MB (Multiemployer Defined Benefit Plan and Certain Money</li></ul>	b	(1) (2)	Sch X	<ul><li>H (Financial Information)</li><li>I (Financial Information – Small Plan)</li></ul>	
а	(1)	on Scl	<ul> <li>R (Retirement Plan Information)</li> <li>MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan</li> </ul>	b	(1) (2) (3)	Sch X	<ul> <li>H (Financial Information)</li> <li>I (Financial Information – Small Plan)</li> <li>A (Insurance Information)</li> </ul>	

	•						
		Insurance	ce Informatio	n		OM	IB No. 1210-0110
(Form 5500 Department of the Treas		This schedule is required	to be filed under section	on 104 of th	e		
Internal Revenue Serv Department of Labo	Internal Revenue Service Employee Retirement Income Security Act of 1974 (ERISA).						2009
Employee Benefits Security Ad	Iministration	File as an a	ttachment to Form 55	600.			
Pension Benefit Guaranty Co	orporation	<ul> <li>Insurance companies a pursuant to E</li> </ul>	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	09 or fiscal plan	year beginning 01/01/2009		and er	nding 12	2/31/2009	
A Name of plan NIAGARA HOSPITALIST	<sup>-</sup> , PC 401(K)/PR	OFIT SHARING PLAN & TRUS	г		e-digit number (P	'N) 🕨	001
0				<b>D</b>			/ <b>_</b>
C Plan sponsor's name a NIAGARA HOSPITALIST		e 2a of Form 5500.		<b>D</b> Emplo 20-199	•	cation Number (	(EIN)
		ing Insurance Contract ( Individual contracts grouped as a					
<b>1</b> Coverage Information:							
(a) Name of insurance ca	rrier						
NATIONWIDE LIFE INSU							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	) From	<b>(g)</b> To
31-4156830	66869	0000NIAG00NY00K		2	12/01/20	009	12/31/2009
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 o	other persons in
(a) Total a	amount of comm	nissions paid		<b>(b)</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	ons or fees	s were paid	
(b) Amount of sales ar	nd base	Fee	s and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) No	ad address of the second law 1					
	(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 and base	F			
commissions paid	(c) Amount	(d) Purpose	<b>(e)</b> C	rganization code
				(= ====)
For Paperwork Reduction Act Notice	Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Sched			v.092308.1 (Form 5500) 2009

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

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

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

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

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

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

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

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may this report.			ay be treated a	s a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end			0
		ent value of plan's interest under this contract in separate accounts at year e				66031
-	Cont	reate With Allegated Funda:			1 1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	33039
	С	Premiums due but unpaid at the end of the year			6c	0
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	1322
		Specify nature of costs CONTRACT COMMISSIONS			···[	
	•	Turne of constructs (4) I individual policies (0) C success defense	ما محمد بالله و			
		Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan o	check here		
7	Conti	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in a	separate accounts)		
				tion guarantee		
				0		
		(3) guaranteed investment (4) dther ►				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
					70(6)	
	- h	(6)Total additions			7c(6)	
		Total of balance and additions (add <b>b</b> and <b>c(6)</b> )	]		7d	
		Deductions:	70(1)			
		(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)	7e(4)			
		▶				
		(5) Total deductions				
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )				
	-			·····		

Schedule A (Form 5500) 2009

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Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	rposes if such contracts	are experience	e-rated as a unit. Whe	ere contract	
8	Bene	efit and contract type (check all applicable boxes)	-				
	a	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d Life insurance
	еГ	Temporary disability (accident and sickness)	f Long-term disabili	ity <b>g</b>	Supplemental unemp	olovment	<b>h</b> Prescription drug
	: [	Stop loss (large deductible)	j HMO contract	., s_ k	PPO contract	Joymon	
	' <u> </u>			r _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Fyne	rience-rated contracts:					
Ŭ		Premiums: (1) Amount received		9a(1)			-
		(2) Increase (decrease) in amount due but unpaid					-
		(3) Increase (decrease) in unearned premium res					1
		(4) Earned ((1) + (2) - (3))		· · · · ·		9a(4)	
		Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves					
		(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)			7
		(B) Administrative service or other fees		9c(1)(B)			7
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			7
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or 🗌 d	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)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entere	d in <b>c(2)</b> .)		9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	
	b	If the carrier, service, or other organization incurr					
		retention of the contract or policy, other than repo	orted in Part I, item 2 abo	ove, report amo	ount	10b	

Specify nature of costs

Part IV	Provision of Information		
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	No

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

	S		Financial In	form	ation—Sr	nall	Plan			OMB No. 1210-01	10
		(Form 5500)	This schedule is required to be filed under section 104 of the Employee								
	De	epartment of the Treasury nternal Revenue Service							2009		
	Employee	Department of Labor Benefits Security Administration			,	,		·	This Form is Open to Public		Bublic
		n Benefit Guaranty Corporation	- File as a	an attac	hment to Form	5500.			1115	Inspection	Fublic
For	calend	ar plan year 2009 or fiscal pl	an year beginning 01/01/200	09		a	and ending	12/	31/2009		
	Name o GARA I		ROFIT SHARING PLAN & TRUS	ST			Three-digit plan numb		•	001	
NIA	GARA I	onsor's name as shown on I HOSPITALIST, PC				20-	mployer Id -1993782				
			fewer than 100 participants as of rule (see instructions). Complete S						ete Scheo	dule I if you are filir	ng as a
Pa	rt I	<b>Small Plan Financial</b>	Information								
ass ben	ets held efit at a	d in more than one trust. Do	ts and liabilities, income, expense not enter the value of the portion me and expenses of the plan inc s to the nearest dollar.	of an in	surance contrac	t that g	juarantees	during th	is plan ye	ear to pay a specifi	ic dollar
1	Plan /	Assets and Liabilities:			<b>(a)</b> Be	ginning	g of Year			(b) End of Year	r
а	Total	plan assets		. 1a				179055			316074
b	Total	plan liabilities		. 1b				0			0
С	Net pl	an assets (subtract line 1b fr	om line 1a)	1c				179055			316074
2	Incon	ne, Expenses, and Transfe	rs for this Plan Year:		(	<b>a)</b> Amo	ount			<b>(b)</b> Total	
а	Contri	butions received or receivab	le:								
	(1) E	Employers		. 2a(1)				16669			
	<b>(2)</b> F	Participants		2a(2)				66677			
	(3)	Others (including rollovers)		2a(3)				0			
b	Nonca	ash contributions						0			
с	Other	income		. 2c				38214			
d			2), 2a(3), 2b, and 2c)								121560
e			overs)					0			
f			ctions)					0			
g	Certai	in deemed distributions of pa	,					0			
h	`	,	alaries, fees, and commissions).					0			
i								191			
i		•	2g, 2h, and 2i)								191
, k			from line 2d)					-			121369
I		. ,	nstructions)	21				-			15650
3	<b>Speci</b> remair	fic Assets: If the plan held as hing in the plan as of the end o	ssets at anytime during the plan yea f the plan year. Allocate the value o one of the specific exceptions descr	ar in any of the pla	n's interest in a co						
					-		Yes	No		Amount	
а	Partne	ership/joint venture interests.			[	3a		Х			
b	Emplo	oyer real property				3b		X			
С	Real	estate (other than employer r	eal property)			3c		Х			
d	Emplo	oyer securities				3d		X			
е	Partic	ipant loans		<u></u>		3e		X			
For	Paper	work Reduction Act Notice	and OMB Control Numbers, s	ee the i	nstructions for	Form	5500			Schedule I (For	m 5500) 200

hedule l	(Form	5500) 2009	
		v.092308.1	

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

Pa	art II Compliance Questions				
4	During 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 pla year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance			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		35000
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		Х	
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?			X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on ar established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parce of real estate, or partnership/joint venture interest?			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?	n, <b>4j</b>		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		
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	
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			
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	es XN	lo Amou	unt:

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)

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

## 5500 Electronic Filing Authorization

Plan Name:Niagara Hospitalist, PC 401(k)/Profit Sharing Plan & TrustEIN/PN:20-1993782/001Plan Year:01/01/2009 - 12/31/2009

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 Plan Sp (sign) (sign) 2-3-12 12-3 - I Z

F	orm 5500	Annual Return/Repo	rt of Employe	e Benefit Plan	OMB No	s. 1210-0110 1210-0089
Intern	triment of the Treasury rnal Revenue Service		2009			
Employ	vee Benefits Security Administration	Complete all entries in accordance with the Instructions to the Form 5500.				
Pension Ber	hefit Guaranty Corporation				This Form is Open to Inspection	Public
Part I	Annual Report	Identification Information				
For the c	alendar plan year 200	9 or fiscal plan year beginning 01	/01/2009	and ending 12/31	L/2009	
A This r	eturn/report is for:	a multiemployer plan;		a multiple-employer	plan; or	
		X a single-employer plan;		a DFE (specify)		
B This r	eturn/report is:	the first return/report;		the final return/report	t;	
		x an amended return/report;		a short plan year retu	um/report (less than 12 m	onths).
C If the	nlan is a collectively-har	gained plan, check here				
-				· · · · · · · · · · · · · · ·		••□
D Checi	k box if filing under:		>	automatic extension;	the DFVC pr	ogram;
		special extension (enter descriptio				
Part II		prmation enter all requested in	formation.			
	me of plan				1b Three-digit plan	001
Ni	agara Hospitalis	t, PC 401(k)/Profit Sharin	g Plan & Trust		number (PN) ►	001
					1c Effective date of pla 01/01/2006	n
2a Pla	in sponsor's name and a	ddress (employer, if for a single-emplo	ver nlan)		2b Employer Identificat	
	Idress should include roo		<b>, ,</b>		Number (EIN)	
•		·			20-1993782	
NI	agara Hospitalis	C, PC			2c Sponsor's telephone	;
					number	
					(716) 828-243	4
42	01 N. Buffalo Ro	ad			2d Business code (see	
					instructions)	
US	Orchard Park	NY 14127			621111	
Contion	A papalty for the late of			waless sees such to source to		
		or incomplete filing of this return/repo per/penalties set forth in the instructions				
statemen	ts and attachments, as	well as the electronic version of this retu	im/report, and to the l	best of my knowledge and be	lief, it is true, correct, and	complete.
SIGN	1		12-3-12	John A. Brach, MD		
HERE	Signature of/plan ad	timbletrator	Date	Enter name of individual sig		
		$\frac{1}{1}$	· · · · · · · · · · · · · · · · · · ·		gring as plan autimistial	,,
SIGN HERE		$K \mid h$	12-3-12	John A. Brach, MD		
	Signature of employ		Date	Enter name of individual sig	gning as employer or plan	sponsor
SIGN						- ·
HERE						

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

Form 5500 (2009) v.092307.1

	Ferm 5500 (2009)	Page 2	
<u>3a</u>	Plan administrator's name and address (if same as plan sponsor, enter "S Same	ame")	3b Administrator's EIN
		-	3C Administrator's telephone number
4	If the name and/or EIN of the plan sponsor has changed since the last retu the plan number from the last return/report:	um/report filed for this plan, enter the name, EIN a	ind 4b EIN
a	Sponsor's name		4C PN
5	Total number of participants at the beginning of the plan year		5 13
6	Number of participants as of the end of the plan year (welfare plans compl	lete only lines 6a, 6b, 6c and 6d)	······································
a	Active participants		<u>6a 14</u>
b	Retired or separated participants receiving benefits		6b o
C	Other retired or separated participants entitled to future benefits		6c 0
d	Subtotal. Add lines 6a, 6b and 6c		6d 14
0	Deceased participants whose beneficiaries are receiving or are entitled to	receive benefits	<b>6e</b> 0
f	Total. Add lines 6d and 6e		6f 14
g	Number of participants with account balances as of the end of the plan year complete this item)	ar (only defined contribution plans	6g 5
h	Number of participants that terminated employment during the plan year w 100% vested		<b>6h</b> 0
7	Enter the total number of employers obligated to contribute to the plan (on		7
	If the plan provides pension benefits, enter the applicable pension feature 2E 2G 2J 3D 3H If the plan provides welfare benefits, enter the applicable welfare feature		
9a		9b Plan benefit arrangement (check all that (1) X Insurance	appiy)
	<ul> <li>(2) Code section 412(e)(3) insurance contracts</li> <li>(3) X Trust</li> </ul>	(2) Code section 412(e)(3) insurance (3) Trust	ce contracts
	(4) General assets of the sponsor	(4) General assets of the sponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules an Repeice Schedules	b Concept Schedules	er allached. (See Instructions)

a	Pension Schedules	b	General Sched	ules
	(1) R (Retirement Plan Information)		(1)	H (Financial Information)
	(2) MB (Muttemployer Defined Benefit Plan and Certain Money		(2) X	I (Financial Information - Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan		(3) X <u>1</u>	A (Insurance Information)
	actuary		(4)	C (Service Provider Information)
	(3) SB (Single-Employer Defined Benafil Plan Actuarial		(5)	D (DFE/Participating Plan Information)
	Information) - signed by the plan actuary		(6)	G (Financial Transaction Information)

## Sponsor Location Information

Sponsor name: Niagara Hospitalist, PC Sponsor DBA name: Sponsor care of name:

4201 N. Buffalo Road

US Orchard Park NY 14127

SCHEDULE A (Form 5500)		Insurance Information			OMB No. 1210-0110			
Department of the Treasury Internal Revenue Service	spartment of the Treasury This schedule is required to be filed under sections 104 of the				f the	2009		
Department of Labor Employee Benefits Security Administ	Department of Labor File as an attachment to Form 5500.							
Pension Benefit Guarenty Corpor	ration	Insurance companies are pursuant to El	required to provide It RISA section 103(a)(2			This Fo	irm is Open to Publi Inspection.	
For calendar plan year 2009	9 or fiscal pla	an year beginning 01/01/20	09	and ending	12/31	/2009		
A Name of plan				B Three-dig plan num		►	001	
iagara Hospitalist,	, PC 401(	(k)/Profit Sharing Plan	& Trust					
C Plan sponsor's name as	s shown on l	line 2a of Form 5500.		D Employer	Indentificatio	n Number (E	in)	
				20-1993782				
		ning Insurance Contract	Coverage Fee	s and Co			formation for each on	
Part   Information	Concerr	ning Insurance Contract ndividual contracts grouped as a u	Coverage, Fee unit in Parts II and III	s, and Col can be reporte	mmission	S Provide in	nformation for each co	
Part I Information on a separate So Coverage Information: (a) Name of insurance carrie	ichedule A. Ir	ndividual contracts grouped as a t	Coverage, Fee unit in Parts II and III	s, and Coi can be reporte	mmission	S Provide in	nformation for each co	
Part I Information on a separate So Coverage Information: (a) Name of insurance carrie ATIONWIDE LIFE INSU	ichadula A. Ir ichadula A. Ir ier JRANCE CO	ndividual contracts grouped as a t	(o) Approximate	can be reporte	mmission	8 Provide ir Schedule A.	· ·	
Part I Information on a separate So Coverage Information: (a) Name of insurance carrie ATIONWIDE LIFE INSU	ichedule A. Ir	ndividual contracts grouped as a t	unit in Parts II and III	number of	mmission	8 Provide in Schedule A. Pelicy or	nformation for each co contract year (g) To	
Part I Information on a separate So Coverage Information: (a) Name of insurance carrie ATIONWIDE LIFE INSU (b) EIN	ichedule A. Ir ichedule A. Ir ier JRANCE CO (c) NAIC	ndividual contracts grouped as a t	(o) Approximate	number of	mmission d on a single	8 Provide in Schedule A. Policy or Dm	contract year	
Part I       Information on a separate So         Coverage Information:         (a) Name of insurance carried         ATIONWIDE LIFE INSU         (b) EIN         (c) 4156830         2         Insurance fee and comm	ichedule A. Ir ichedule A. Ir ier JRANCE CO (c) NAIC code 66869 mission infor	(d) Contract or identification number 0000NIAG00NY00K mation. Enter the total fees and to	(o) Approximate persons covered pelicy or conti	number of d at end of act year 2	(f) From 12/1/20	S Provide in Schedule A. Policy of Dm	contract year (g) To 12/31/2009	
Part I       Information on a separate So         Coverage Information:         (a) Name of insurance carried         ATIONWIDE LIFE INSU         (b) EIN         (c) EIN         (c) T-4156830         2         Insurance fee and commutes         descending order of the	ichedule A. Ir ichedule A. Ir ier JRANCE CO (c) NAIC code 66869 mission infor a amount pai	(d) Contract or identification number 0000NIAG00NY00K mation. Enter the total fees and to	(o) Approximate persons covered pelicy or conti	number of d at end of act year 2 d. List in item 3	(f) From 12/1/20	S Provide in Schedule A. Policy of Om DO9 brokers, and	contract year (g) To 12/31/2009	
Part I       Information on a separate So         Coverage Information:         (a) Name of insurance carried         ATIONWIDE LIFE INSU         (b) EIN         1-4156830         2         Insurance fee and communication         descending order of the	ichedule A. Ir ichedule A. Ir ier JRANCE CO (c) NAIC code 66869 mission infor a amount pai	(d) Contract grouped as a v (d) Contract or identification number 0000NIAG00NYOOK matien. Enter the total fees and to id.	(o) Approximate persons covered pelicy or conti	number of d at end of act year 2 d. List in item 3	(f) From 12/1/20 (f) the agents,	S Provide in Schedule A. Policy of Om DO9 brokers, and	contract year (g) To 12/31/2009	
on a separate Si         1       Coverage Information:         (a) Name of insurance carrie         (ATIONWIDE LIFE INSU         (b) EIN         (b) EIN         (c) EIN </td <td>ichedule A. Ir ichedule A. Ir ier JRANCE CO (c) NAIC code 66869 mission infor a amount pata amount of co</td> <td>(d) Contracts grouped as a v (d) Contract or identification number 0000NIAG00NY00K mation. Enter the total fees and to d. mmissions paid</td> <td>(0) Approximate persons covered pelicy or conti policy or conti otal commissions pair</td> <td>number of d at end of act year 2 d. List in item 3 (b) Total all persons).</td> <td>(f) From 12/1/20 (f) amount of fe</td> <td>S Provide in Schedule A. Policy or Om DO9 brokers, and es paid 0</td> <td>contract year (g) To 12/31/2009</td>	ichedule A. Ir ichedule A. Ir ier JRANCE CO (c) NAIC code 66869 mission infor a amount pata amount of co	(d) Contracts grouped as a v (d) Contract or identification number 0000NIAG00NY00K mation. Enter the total fees and to d. mmissions paid	(0) Approximate persons covered pelicy or conti policy or conti otal commissions pair	number of d at end of act year 2 d. List in item 3 (b) Total all persons).	(f) From 12/1/20 (f) amount of fe	S Provide in Schedule A. Policy or Om DO9 brokers, and es paid 0	contract year (g) To 12/31/2009	

(b) Amount of sales and base	Fees a		
commissions paid	(C) Amount	(d) Purpose	(e) Organization code
	<u>l</u>		
(a) Name ar	nd address of the agent, broker, or c	other person to whom commissions or fees were	e paid

(b) Amount of seles and base	Fees an		
(b) Amount of sales and base commissions paid	(C) Amount	(d) Purpose	(e) Organization code

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

(b) Amount of sales and base	F		
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	Amount of sales and base Fees and citier 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

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

(b) Amount of sales and base	Fees		
commissions paid	(c) Amouni	(d) Purpose	(o) Organization code

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

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

Pa	rt II Investment and Annuity Contract Information			
	Where Individual contracts are provided, the entire group of such ind this report.	ividual contracts with each carrier r	may be treated a	as a unit for purposes of
<u>4</u>	Current value of plan's interest under this contract in the general account at year		· 4	0
5	Current value of plan's interest under this contract in separate accounts at year	end	. 5	66,031
6	Contracts With Allocated Funds: a State the basis of premium rates			
	NOT PROVIDED BY INSURANCE CO.			
	b Premiums paid to carrier			
	C Premiums due but unpaid at the end of the year	• • • • • • • • • • •	• <u>6b</u>	33,039
	d If the carrier, service, or other organization incurred any specific costs in co		• <u>6c</u>	0
	or relention of the contract or policy, enter amount		6d	1,322
	Specify nature of costs >		•	1,322
	CONTRACT COMMISSIONS			
	B Type of contract (1) 🙀 individual policies (2) 🗌 group deferred ar	nnuity		
	(3) other (specify) ►	•		
			_	
	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan check here	▶□	
7	Contracts With Unallocated Funds (Do not include portions of these contracts a	maintained in separate accounts)		
a	Type on contract (1) 🗌 deposit administration (2) 🗍 i	mmediate participation guarantee		
	(3) 🗍 guaranteed investment (4) 🗍 (	other <b>&gt;</b>		
b	Balance at the end of the previous year	• • • • • • • • • • • • • • • • • • •	<u>7</u> b	
C	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account	.7c(4)		
	(5) Other (specify below)	7c(5)		
	•			
			7-(0)	
	(6) Total additions	• • • • • • • • • • •	7 <u>c(6)</u>	
	Total of balance and additions (add b and c(6)) • • • • • • • • • • • • • • • • • •	· · · · · · · · · · · · · · · · · · ·	<u>7d</u>	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(1) Disputsed from table to pay definition of periodiase annumes during year (2) Administration charge made by carrier	7e(1)		
	(2) Administration charge made by carrier	7e(2) 7e(3)		
	(4) Other (specify below)	7e(4)		
	-			
	(5) Total deductions		7e(5)	
f	Relance at the end of the current year (subtract e(5) from d).		7f	

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Pa	t III   Welfare Benefit Contract Information		
	If more than one contract covers the same group of employees of the same	employer(s) or members of the same emp	loyee organization(s), the
	information may be combined for reporting purposes if such contracts are ex	perience-rated as a unit. Where contracts	cover individual employees.
	the entire group of such individual contracts with each carrier may be treated	as a unit for purposes of this report.	
8	Benefit and contract type (check all applicable boxes)		
	a 📙 Health (other than dental or vision) b 📃 Dental	C 📙 Vision	d 🔲 Life Insurance
	e 📙 Temporary disability (accident and sickness) f 📋 Long-term disability	g 🗌 Supplemental unemployment	h Prescription drug
	i 🗌 Stop loss (large deductible) j 🔲 HMO contract	k PPO contract	I Indemnity contract
	m Other (specily) ►	9	
_			
9	Experience-rated contracts		_
a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))	<u> 9a(4)</u>	
b	Benefit charges: (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))	· · · · · · · · · 9b(3)	
	(4) Claims charged	••••••••••••••••••••••••••••••••••••••	
C	Remainder of premium: (1) Retention charges (on an accrual basis) -		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	1
	(C) Other specific acquisition costs	9c(1)(C)	1
	(D) Other expenses	9c(1)(D)	1
	(E) Taxes	9c(1)(E)	1
	(F) Charges for risks or other contingencies	9c(1)(F)	1
	(G) Other retention charges	9c(1)(G)	1
	(H) Total retention	· · · · · · · · · · 9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (The amounts were and paid in cash,		
d	Status of policyholder reserves at end of year. (1) Amount held to provide benefits		· · ···
-	(2) Claim reserves		-
	(3) Other reserves	· · · · · · · · · · · 9c(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in $c(2)$ .)	9e	
10	Nonexperience-rated contracts:		
a	Total premiums or subscription charges paid to carrier	<b>10a</b>	
b	If the carrier, service, or other organization incurred any specific costs in connection		
	retention of the contract or policy, other than reported in Part I, item 2 above, report		1
	reterment of the contract of power, unlet maintabuted at Last 1 ment a apple, tehost		

Specify nature of costs >

Part IV Provision of Information	
11 Did the insurance company fall 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				0	MB No. 1210-0110		
	(Form 5500)	This schedule is required to be filed under section 104 of the Employee					0000		
	Department of the Troosway Internat Rovonue Service	Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).					2009		
	Department of Labor replayee Banefits Security Administration	<ul> <li>File as an attachment to Form 5500.</li> </ul>					This F	orm is Open to Public Inspection.	
	Pension Banefa Guaranty Corporation		01/01/2009		and ending	- 12/3	1/2009		
_	calendar plan year 2009 or fiscal plan	year ceginning	01/01/2009			B Three			······
	Name of plan Niagara Hospitalist, PC 4	AT IN I Dealin Ch	anting Blan C	Truct			number		001
i	Nlagara Hospitalist, PC 4	VI(K)/PFOLIC SH	iattuð stau a	ILUBC		- piarri	I MATTE GT		
C	Plan sponsor's name as shown on lin	e 2a of Form 5500	<u></u>	- <u></u> .		D Empl	loyer Ider	ntification I	Number (EIN)
	Niagara Hospitalist, PC					20-:	199378	2	
small	lete Schedule I if the plan covered few plan under the 80-120 participant rule Int I Small Plan Financial	(see instructions). Cor	its as of the beginni mplete Schedule H	ng of the plan if reporting as	i year. You m 3 a large plan	nay also co or DFE.	mplete S	ichedule I	il you are filing as a
assets benefi	t below the current value of assets and the lot in more than one trust. Do not e t at a future date. Include all income a noe carriers. Round off amounts to t	inter the value of the pl and expenses of the pl	ortion of an insuran	ce contract th	nat guarantee	es during th	us plan ye	ear to pay	a specific dollar
1	Plan Assots and Liabilities:				(a) Beginni	ing of Year		(b) En	d of Year
a	Total clan assets			1a		17	9,055		316,074
Б	Total clan liabilities			1b			0		0
_	Net plan assets (subtract line 1b from	n line 1a) <u>.</u>		1c		17	9,055		316,074
2	Income, Expenses, and Transfe				(a) Arno	ount		(b	) Total
а	Contributions received or receivable								
	(1) Employers		. <b></b>	2a(1)		1	6,669		
	(2) Participants	. <b></b> .	. <b></b> .	2a(2)		6	6,677		
	(3) Others (including rollovers) .		. <b></b>	2a(3)			0		
Ь	Noncash contributions		, <b></b> .	2b			0		
C	Other income			2c		3	8,214		
d	Total income (add lines 2a(1), 2a(2),	, 2a(3), 2b, and 2c)		2d					121,560
е	Benefits paid (including direct rollove	ers)	• • • • • •	<u>2e</u>			0		
f	Corrective distributions (see instructi	ions)	• • • • • •	<b>2f</b>	<u> </u>		0		
g	Certain deemed distributions of parti	icipant loans							
	(see instructions)		• • • • • •	<u>2g</u>			0		
h	Administrative service providers (sal	aries, fees, and commi	issions)	<u>2h</u>			0		
i	Other expenses	,	. <b></b>	2i	<u></u>		191		
j	Total expenses (add lines 2e, 2f, 2g,	, 2h and 2i)		2	1				191
k	Net income (loss) (subtract line 2j fro				1				121,369
_1	Transfers to (from) the plan (see inst	tructions)	• • • • • •	21	L				15,650
3	Specific Assets: If the plan held asse remaining in the plan as of the end of the by-line basis unless the trust meets one of	plan year. Allocate the v	raiue of the plan 's inte	irest in a comm	jorias, check " lingled trust cor	Yes" and en n taining the	ter the cur assets of	rent value ( more than (	of any assets one plan on a line-
						Yes	No	A	mount
а	Partnership/joint venture interests				3	a	x		
b	Employer real property				3	b	x		
c	Real estate (other than employer rea	al property)			3	C	x		
ď	Employer securilies				3		x		
	- <del>-</del>				3	- I	X	1	

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			Yes	No	Amount
3f	Loans (other than to participants)	3f		x	
9	Tangiblo personal property	3g		X	
Part	I 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 Volunts ry Fiduciary Correction Program)	<b>4</b> a		x	
b	Were any leans by the plan or fixed income obliga tions due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant leans secured by the perticipants' account balance	4b		x	
C	Were any leases to which the plan was a party in default or classified during the year as uncolloctible?	4c		x	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 42.)	4d		x	
0	Was the plan covered by a fidelity bond?	40	x		35,00
f	Did the plan have a loss, whether or not roi mburaod by the plan's fidelity band, that was caused by fraud or dishonesty?	4f		x	
9	Did the plan hold any assets whose currant value was notther readily determinable on an established market nor set by an independent third party appraiser?	4g		x	
h	Did the plan receive any noncash contri butions whose value was notther readily determinable on an established market nor set by an independent thir d party appraiser?	4h		x	_
1	Did the plan at any time hold 20% or more of its assets in any single security, dobt, mortgage, parcel of real estate, or partnership/joint vanture 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?	<u>4j</u>		x	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 25 CFR 2520.104-467 if "No", attach the IQPA's report or 2520.104-60 statement. (See instructions on waiver eligibility and conditions.)	4k	x		
1	Has the plan failed to provide any be nefit 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.)	<u>4m</u>		×	
n	if 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice a pplied under 29 CFR 2520.101-3	4n			
- <b>6</b> a	Has a resolution to terminate the plan basin 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 Yes 🔀 No Amount				
6b	If during this plan yoar, any assets or liabilities were transforred from this plan to another plan(e), identif	fy the p	ila n(s) to	» which asse	no ar llabilitles were
	transforrod. (See instructions.)		.(1)		E5/23
	5b(1) Name of plan(s)		<b>)(2)</b>	EIN(a)	5b(3) PN(a)