-	Bonofit Plan							10-0110 10-0089	
Internal Revenue Service This form is required to be filed under sections 104 and 4065 of the Employe						2	2012		
	epartment of Labor enefits Security Administration	8(a) of This Form is Open to Public Inspection			ublic				
Pension Be	enefit Guaranty Corporation	)-SF.	1113	pection					
Part I		Ientification Information			<u></u>				
For calenda	ar plan year 2012 or fisca				2/31/2	2012			
A This ret	urn/report is for:	X a single-employer plan	a multiple-employer pl	an (not multiemployer)		a one-particip	oant plan		
B This ret	urn/report is:	the first return/report X t	he final return/report						
		onths	)						
C Check box if filing under: Form 5558 automatic extension						DFVC progra	ım		
	[	special extension (enter description	)						
Part II	Basic Plan Inform	mation—enter all requested informat	ion						
<b>1a</b> Name	•				1b	Three-digit			
MARK MER	GLER DDS PC PROFIT	SHARING PLAN				plan number (PN) ►	003		
					1c	Effective date of			
					10	01/01/			
2a Plan sj MARK MER		ess; include room or suite number (em	ployer, if for a single-	employer plan)	2b		fication Num 27868	ber	
57 W 57TH 3	ST. SUITE 702				2c	Sponsor's telephone number 212-688-3472			
57 W 57TH ST, SUITE 702 NEW YORK, NY 10019						Business code (see instructions) 621210			
3a Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address						3b Administrator's EIN			
<ul> <li>If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.</li> </ul>									
a Spons					<b>4c</b> PN				
5a Total r	number of participants at	t the beginning of the plan year			5a 5				
<b>b</b> Total r	number of participants at	the end of the plan year			5b			0	
		count balances as of the end of the pla			5c			0	
		during the plan year invested in eligible					X Yes	No	
		ne annual examination and report of ar					103		
		See instructions on waiver eligibility ar					X Yes	No	
lf you	answered "No" to eith	er line 6a or line 6b, the plan canno	t use Form 5500-SF	and must instead use	Form	5500.			
		incomplete filing of this return/repo							
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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. 03/01/2013 MARK MERGLER									
HERE	HERE Signature of plan administrator Date Enter name of individ					gning as plan adn	ninistrator		
SIGN	Filed with authorized/va	lid electronic signature.	03/01/2013	MARK MERGLER					
HERE         Signature of employer/plan sponsor         Date         Enter name of individ           Preparer's name (including firm name, if applicable) and address; include room or suite number (optional)         Enter name of individ									
Preparer's	name (including firm nar	ne, if applicable) and address; include	room or suite number	r (optional)	Prep	parer's telephone	number (opt	tional)	

Part III Financial Information							
7 Plan Assets and Liabilities		(a) Beginning of Yea	r		(b) End of Year		
a Total plan assets				0			
<b>b</b> Total plan liabilities	7b		0		0		
C Net plan assets (subtract line 7b from line 7a)	7c	3517	3		0		
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount			(b) Total		
a Contributions received or receivable from:							
(1) Employers	8a(1)	616					
(2) Participants	8a(2)		0				
(3) Others (including rollovers)	8a(3)		0				
<b>b</b> Other income (loss)	8b	102	1				
<b>C</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c				7188		
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	4236	1				
e Certain deemed and/or corrective distributions (see instructions)	8e		0				
f Administrative service providers (salaries, fees, commissions)	8f		0				
g Other expenses	8g		0				
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		-		42361		
Net income (loss) (subtract line 8h from line 8c)	8i				-35173		
Transfers to (from) the plan (see instructions)	8j		0		00110		
Part IV Plan Characteristics	oj		0				
<ul> <li>9a If the plan provides pension benefits, enter the applicable pension 2D 2E 2J</li> <li>b If the plan provides welfare benefits, enter the applicable welfare fee</li> <li>Part V Compliance Questions</li> </ul>							
				res No	A		
<ul> <li>During the plan year:</li> <li>Was there a failure to transmit to the plan any participant contribu 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu</li> </ul>			10a	X	Amount		
<ul> <li>b Were there any nonexempt transactions with any party-in-interest on line 10a.)</li> </ul>	ude transactions reported	10a	x				
<b>C</b> Was the plan covered by a fidelity bond?			100	Х			
d Did the plan have a loss, whether or not reimbursed by the plan's	a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud 10c 10c 10c 10c 10c			x			
e Were any fees or commissions paid to any brokers, agents, or oth insurance service or other organization that provides some or all or instructions.)	of the benefits	under the plan? (See	10e	x			
	les the plan failed to provide any basefit when due we den the plan?			Х			
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount a	s of vear end	)	10f	Х			
h If this is an individual account plan, was there a blackout period?	a the plan have any participant loans? (If "Yes," enter amount as of year end.)			X			
<ul> <li>If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101</li> </ul>	ne required no	otice or one of the	10i				
Part VI Pension Funding Compliance							
11 Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)							
11a Enter the amount from Schedule SB line 39	1a Enter the amount from Schedule SB line 39 11a						
12 Is this a defined contribution plan subject to the minimum funding					ERISA? Yes X No		
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,							
, ,							
<b>a</b> If a waiver of the minimum funding standard for a prior year is beir granting the waiver.	ng amortized i	n this plan year, see instruc		and enter th Day	ne date of the letter ruling Year		
	ng amortized i	n this plan year, see instruc			•		

С	Enter the amount contributed by the employer to the plan for this plan year	12c		
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d		
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No N/A
Part	VII Plan Terminations and Transfers of Assets			
13a	Has a resolution to terminate the plan been adopted in any plan year?	X	Yes No	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a		0
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under t of the PBGC?	e control		X Yes No
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan which assets or liabilities were transferred. (See instructions.)	s) to		_
1	13c(1) Name of plan(s):	13c(2) E	IN(s)	<b>13c(3)</b> PN(s)
Part	t VIII Trust Information (optional)			

14a Name of trust	14b Trust's EIN

TO:12033561045

A This return/report is for:       x a single-employer plan       a multiple-employer plan (not multiemployer)         B This return/report is:       the first return/report       x the final return/report         B This return/report is:       the first return/report       x the final return/report         C Check box if filing under:       Form 5558       a automatic extension         C Check box if filing under:       Form 5558       automatic extension         Part II       Basic Plan Information enter all requested information       1         1A Name of plan       1b         Mark Mergler DDS PC Profit Sharing Plan       1c         2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b         Mark Mergler DDS       702       2d         US New York       NY 10019       3a         3a Plan administrator's name and address       X Same as Plan Sponsor Name       Same as Plan Sponsor Address         3b       3c       3c         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, and the plan number from the last return/report.       4b	2012         This Form Is Open to Public Inspection         Inspection         2/31/2012       a one-participant plan         a one-participant plan       DFVC program         Three-digit plan number (PN) ▶       003         Effective date of plan 01/01/2006       01/01/2006         Employer Identification Number (EIN) 13-3027868       Sponsor's telephone number (212) 688-3472         Business code (see instructions) 621210       Administrator's EIN				
Employee sendits Society Administration       ► Complete all entries in accordance with the instructions to the Form 5500-SF.         Part I       Annual Report Identification Information       01/01/2012       and ending       1         A This return/report is for:       a single-employer plan       a multiple-employer plan (not multiemployer)       It is return/report         B This return/report is:       the first return/report       a shot plan year 2012 of fiscal plan year beginning       01/01/2012       and ending       1         C Check box if filing under:       Form 5558       a utomatic extension       special extension (enter description)       .       .         Part II       Basic Plan Information enter all requested information       1       1       .       .         A Name of plan       isocity of the plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b         Mark Mergler DDS PC Profit Sharing Plan       1c         2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b         Mark Mergler DDS       NY 10019       .       .         3a Plan administrator's name and address [K] Same as Plan Sponsor Name Same as Plan Sponsor Address	Inspection 2/31/2012 a one-participant plan DFVC program Three-digit plan number (PN) ▶ 003 Effective date of plan 01/01/2006 Employer Identification Number (EIN) 13-3027868 Sponsor's telephone number (212) 688-3472 Business code (see instructions) 621210				
Persion Benefit Guaranty Corporation <ul> <li>Complete all entries in accordance with the instructions to the Form 5500-SF.</li> <li>Part 1</li> <li>Annual Report Identification Information</li> <li>For calendar plan year 2012 or fiscal plan year beginning</li> <li>O1/01/2012 and ending</li> <li>This return/report is for:</li> <li>a single-employer plan</li> <li>a multiple-employer plan (not multiemployer)</li> <li>B This return/report is:</li> <li>the first return/report</li> <li>a single-employer plan</li> <li>a work plan year return/report (less than 12 months)</li> <li>C Check box if filing under:</li> <li>Form 5558</li> <li>automatic extension</li> <li>special extension (enter description)</li> <li>Part II</li> <li>Basic Plan Information enter all requested information</li> <li>Name of plan</li> <li>Mark Mergler DDS FC Profit Sharing Plan</li> <li>Mark Mergler DDS</li> <li>FOR 57th St., Suite 702</li> <li>New York</li> <li>NY 10019</li> <li>Plan administrator's name and address</li> <li>Same as Plan Sponsor Address</li> <li>Plan administrator's name and address</li> <li>Same as Plan Sponsor Address</li> <li>Total number of participants at the beginning of the plan year</li> <li>Ga Total number of participants at the eding of the plan year</li> <li>Same as Plan Sponsor's name</li> <li>Same as of the entity report.</li> <li>Same as Plan Sponsor Address</li> <li>Same of plan under of participants at the end of the plan year</li> <li>Same as Plan Sponsor Address</li> <li>Same as Plan number</li></ul>	2/31/2012 a one-participant plan DFVC program Three-digit plan number (PN) ▶ 003 Effective date of plan 01/01/2006 Employer Identification Number (EIN) 13-3027868 Sponsor's telephone number (212) 688-3472 Business code (see instructions) 621210				
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For calendar plan year 2012 or fiscal plan year beginning       01/01/2012       and ending       1         A This return/report is for:       Image: a single-employer plan       a multiple-employer plan (not multiemployer)         B This return/report is:       Image: the first return/report       Image: and ending       1         C Check box if filing under:       Form 5558       Image: automatic extension       Image: automatic extension         Image: special extension (enter description)       Image: special extension (enter description)       Image: special extension (enter description)         Part II       Basic Plan Information enter all requested information       1         1a Name of plan       Image: special extension (enter description)       Image: special extension (enter description)         Mark Mergler DDS PC Profit Sharing Plan       Image: special extension enter all requested information       1         Mark Mergler DDS       PC Profit Sharing Plan       Image: special extension enter all requested information       2         2a Plan sponsor's name and address:       Image: special extension enter all requested information       2       2         3a Plan administrator's name and address       Image: special extension enter all requested ince the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.       3       3         3a Total number of participants at the beginning of	a one-participant plan         DFVC program         Three-digit plan number (PN) ▶         003         Effective date of plan 01/01/2006         Employer Identification Number (EIN) 13-3027868         Sponsor's telephone number (212) 698-3472         Business code (see instructions) 621210				
A This return/report is for:       Image: a single-employer plan       Image: a multiple-employer plan       Image: a multiple-employer plan       Image: a multiple-employer plan         B This return/report is:       Image: the first return/report       Image: a short plan year return/report       Image: a short plan year return/report         C Check box if filing under:       Form 5558       Image: automatic extension         Image: plan year return/report       Image: a short plan year return/report (less than 12 months)         Part III       Basic Plan Information enter all requested information         1a Name of plan       Image: plan here and address; include room or suite number (employer, if for a single-employer plan)         Mark Mergier DDS PC Profit Sharing Plan       Ic         2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b         Mark Mergier DDS       Mark Mergier DDS       2c         57 W 57th St, Suite 702       2d         US New York       NY 10019       3c         3a Plan administrator's name and address       Image: Same as Plan Sponsor Name is Same as Plan Sponsor Address       3b         3c       Total number of participants at the beginning of the plan year       5a         5a Total number of participants at the end of the plan year       5a         5a Were all of the plan's assets during the plan year invested in	DFVC program Three-digit plan number (PN) ► 003 Effective date of plan 01/01/2006 Employer Identification Number (EIN) 13-3027868 Sponsor's telephone number (212) 688-3472 Business code (see instructions) 621210				
B       This return/report is:       ihe first return/report       in a mended return/report       in a short plan year return/report (less than 12 months)         C       Check box if filing under:       Form 5558       in automatic extension         is special extension (enter description)       is special extension (enter description)       is special extension (enter description)         Part II       Basic Plan Information enter all requested information       10         Mark Mergler DDS       PC Profit Sharing Plan       10         Mark Mergler DDS       PC Profit Sharing Plan       10         2a       Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b         Mark Mergler DDS       S7 W 57th St, Suite 702       2d         US       New York       NY 10019       2c         3a       Plan administrator's name and address       S Same as Plan Sponsor Name is Same as Plan Sponsor Address       3b         3c	DFVC program Three-digit plan number (PN) ► 003 Effective date of plan 01/01/2006 Employer Identification Number (EIN) 13-3027868 Sponsor's telephone number (212) 688-3472 Business code (see instructions) 621210				
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2a       Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b         Mark Mergler DDS       2c         57 W 57th St. Suite 702       2d         US New York       NY 10019         3a       Plan administrator's name and address       X Same as Plan Sponsor Name Same as Plan Sponsor Address       3b         3a       If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.       3c         4       If the name of participants at the beginning of the plan year       4c         5a       Total number of participants at the end of the plan year       5a         5b       Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)       5c         6a       Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)       5c         b       Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)	01/01/2006 Employer Identification Number (EIN) 13-3027868 Sponsor's telephone number (212) 698-3472 Business code (see instructions) 621210				
Mark Mergler DDS       2c         57 W 57th St. Suite 702       2d         US New York       NY 10019         3a Plan administrator's name and address IX Same as Plan Sponsor Name Same as Plan Sponsor Address       3b         3c       3c         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, and the plan number from the last return/report.       4c         a Sponsor's name       4c         5a Total number of participants at the beginning of the plan year       5a         b Total number of participants at the end of the plan year       5b         c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)       5c         6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)       5c         b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)	(EIN) 13-3027868 Sponsor's telephone number (212) 688-3472 Business code (see instructions) 621210				
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<ul> <li>complete this item)</li></ul>	<u> </u>				
<ul> <li>6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)</li> <li>b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)</li> </ul>	0				
b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)	XYes No				
under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)					
	X Yes No				
IL AON SURANDICO NO TO BITURI ILLA DA OL ILLA OD' TILA DATI CULLIOL OPP L'OLLA DATI ANA LIPOLA ANA MARCA MARCA ANA MARCA					
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is					
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, in	cluding, if applicable, a Schedule				
SB or Schedule MB completed and signed/by an enrolled actuary, 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 Mun Muss 2/22/28/15 Mark Mergler					
HERE Signature of plan administrator Date Enter name of individual sign	ing as plan administrator				
2/22 /LU/3 Mark Mergler					
SIGN					
	arer's telephone number (optional)				
1					

## Part III Financial Information

_	rt III   Financial Information		(a) Designing of Veer			(b) End a	f Voor		
	Plan Assets and Liabilities	_	(a) Beginning of Year	_		(b) End o	or rear 0		
	Total plan assets	7a	35,17						
	Total plan liabilities	7b		0	0				
	Net plan assets (subtract line 7b from line 7a)	7c	35,17	3		0			
	Income, Expenses, and Transfers for this Plan Year Contributions received or receivable from:		(a) Amount	-	(b) Total				
	(1) Employers	8a(1)	6,16	7					
-	(2) Participants	8a(2)		0					
	(3) Others (including rollovers)	8a(3)		0					
_	ber income (loss)         8b         1,021								
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)         8c         7,188								
	Benefits paid (including direct rollovers and insurance premiums								
	to provide benefits)								
е	Certain deemed and/or corrective distributions (see instructions) 8e 0								
f	Administrative service providers (salaries, fees, commissions)	8f		0					
g	Other expenses	8g		0					
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					42,361		
i	Net income (loss) (subtract line 8h from line 8c)	8i					(35,173)		
j	Transfers to (from) the plan (see instructions)	8j		0					
Pa	rt IV Plan Characteristics								
9a       If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:         2D       2E       2J         b       If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:									
Ра	rt V Compliance Questions								
10	During the plan year:			Y	es No	0	Amount		
а	Was there a failure to transmit to the plan any participant contribut 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduc			10a	x				
b	Were there any nonexempt transactions with any party-in-interest? on line 10a.)		-	10b	x				
С	Was the plan covered by a fidelity bond?		••••••	10c	x				
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?								
e	Were any fees or commisions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)				x				
f	Has the plan failed to provide any benefit when due under the plan	n? <b></b>		10f	x				
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of vear e	nd.)	10g	x				
h					x				
i	If 10h was answered "Yes," check the box if you either provided th exceptions to providing the notice applied under 29 CFR 2520.101	e required	notice or one of the	10i					
Pa									
11	11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form								
114	, , ,								
	a Enter the amount from Schedule SB line 39								
12	Is this a defined contribution plan subject to the minimum funding r	requireme	nts of section 412 of the Code or	section	302 of	ERISA?	Yes X No		
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,	as applica	able.)						
a 	If a waiver of the minimum funding standard for a prior year is bein granting the waiver	0		-		the date of th Day	e letter ruling Year		
lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule	MB (Forn	n 5500), and skip to line 13.			1			
b	Enter the minimum required contribution for this plan year	••••••	******		. 12b				
-					•	-			

Form 5500-SF 2012

С	Enter the	amount contributed by the employer to the plan for this plan year	12c				
d		he amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a amount)	12d				
е	e Will the minimum funding amount reported on line 12d be met by the funding deadline?						
Part	VII P	Ian Terminations and Transfers of Assets					
13a	Has a reso	olution to terminate the plan been adopted in any plan year?	X Y	es 🗆 M	No		
	lf "Yes," e	nter the amount of any plan assets that reverted to the employer this year	13a			0	
b	<b>b</b> Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the c of the PBGC?				X Yes 🗌 No		
С		nis plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to ets or liabilities were transferred. (See instructions.)	I				
1	3c(1) Nam	e of plan(s): 13	<b>:(2)</b> EIN(	(s)	13c(3	<b>8)</b> PN(s)	
_							
Part	VIII	rust Information (optional)					

14a Name of trust	14b Trust's EIN