

<b>Form 5500-SF</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation		<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b>  This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).  ▶ <b>Complete all entries in accordance with the instructions to the Form 5500-SF.</b>		OMB Nos. 1210-0110 1210-0089  <b>2016</b>  <b>This Form is Open to Public Inspection</b>	
<b>Part I Annual Report Identification Information</b>					
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016					
<b>A</b> This return/report is for:		<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) <input type="checkbox"/> a one-participant plan <input type="checkbox"/> a foreign plan			
<b>B</b> This return/report is		<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)			
<b>C</b> Check box if filing under:		<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)			
<b>Part II Basic Plan Information</b> —enter all requested information					
<b>1a</b> Name of plan HERBERT TARAGIN, DDS, PC EMPLOYEES RETIREMENT PLAN - PROFIT SHARING		<b>1b</b> Three-digit plan number (PN) ▶		002	
		<b>1c</b> Effective date of plan		01/01/1979	
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) HERBERT TARAGIN, DDS, PC  7000 BAY PARKWAY BROOKLYN, NY 11204		<b>2b</b> Employer Identification Number (EIN)		11-2478724	
		<b>2c</b> Sponsor's telephone number		718-236-4389	
		<b>2d</b> Business code (see instructions)		621210	
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		<b>3b</b> Administrator's EIN			
		<b>3c</b> Administrator's telephone number			
<b>4</b> 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.		<b>4b</b> EIN			
<b>a</b> Sponsor's name		<b>4c</b> PN			
<b>5a</b> Total number of participants at the beginning of the plan year .....		<b>5a</b>		2	
<b>b</b> Total number of participants at the end of the plan year.....		<b>5b</b>		0	
<b>c</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		<b>5c</b>		0	
<b>d(1)</b> Total number of active participants at the beginning of the plan year.....		<b>5d(1)</b>		2	
<b>d(2)</b> Total number of active participants at the end of the plan year .....		<b>5d(2)</b>		0	
<b>e</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....		<b>5e</b>			
<b>Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.</b>					
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.					
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	10/07/2017	HERBERT TARAGIN		
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator		
<b>SIGN HERE</b>					
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor		
Preparer's name (including firm name, if applicable) and address (include room or suite number )				Preparer's telephone number	









