2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Jun 29, 2005 8:00 am
Secretary of State
04-28-2005 90049 001 *3,150.00

DOCUMENT # L04000020840

1. Entity Name
ROBERT A. ROSS MD, LLC

300009044 - /

Principal Place of Business	Mailing Address
3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741	3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741

04202005 Chg-LLC CR2E083 (10/03)

2. Principal Place of Business		3. Mailing Address	
9150 SW 87 Ave			
Suite, Apt. #, etc.: Ste. 212		Suite, Apt. #, etc.	
City & State: Miami, FL		City & State	
Zip: 33176	Country: U.S.A.	Zip	Country

4. FEI Number: 54-2129332 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ $5.00 Additional Fee Required

6. Name and Address of Current Registered Agent

YELEN, MITCHELL A
3225 AVIATION AVE., SUITE 500
MIAMI, FL 33133-4741

7. Name and Address of New Registered Agent

Name
Street Address (P.O. Box Number is Not Acceptable)
City FL Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE ____________________
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

Filing Fee is $50.00
Due by May 1, 2005

Make check payable to Florida Department of State

9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	MANAGER Robert Boyett, MD 8955 S.W. 87 Court. # 214 Miami, FL 33176	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
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TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition

11. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE: Mitchell A. Yelen 04/25/05 305-858-5800
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #

Mitchell A Yelen

ATTACHMENT 30009822
#L04000020840

STATE OF FLORIDA
OFFICE OF THE COMPTROLLER
APPLICATION FOR REFUND

Section 215.26, Florida Statutes, states in part: "Applications for refunds as provided in this section shall be filed with the Comptroller, except as otherwise provided herein, within 3 years after the right to such refund shall have accrued else such right shall be barred." Three years is generally interpreted as meaning three years from the date of payment into the State Treasury. The Comptroller has delegated the authority to accept applications for refund to the unit of State government which initially collected the money.

Pursuant to the provisions of Rule 3A-44.020, Florida Administrative Code, and Section 215.26, Florida Statutes, or Section _____*, Florida Statutes, I hereby apply for a refund of moneys I paid into the State Treasury, which are subject to refund. The following information is submitted to substantiate the claim.

THE INFORMATION IN THIS BOX WILL BE USED TO WRITE AND MAIL YOUR REFUND CHECK. PLEASE TYPE OR PRINT LEGIBLY.

Name: _____ EIN or SS#: _____

Address: _____

_____

Amount: _____ Date Paid: _____

Reason for Claim: _____

_____

_____.

Certified true and correct this _____ ***day of*** _____, _____.

Signature _____

* Must be completed if authority is other than Section 215.26, Florida Statutes.

Do Not Write in This Box - For Agency Use Only

Amount of recommended refund $ 50.00

The amount requested above was originally deposited into the State Treasury, as a part of the funds deposited on

State Treasurer's Receipt No. A00049-001 *dated* 4/28/05

NAME OF ACCOUNT: 45101000132453001000001000000

Statutory Authority for Collection 608.0452

It is requested that payment be made from the following account:

NAME OF ACCOUNT: 45101000132453001000022002000

Certified true and correct this _____ *day of* _____, _____

Department of State, Division of Corporations _____

(Agency) **(Authorized Agency Signature and Title)**

CR2E060(7/03)

5/31/05 CORPORATE DETAIL RECORD SCREEN 1:59 PM

NUM: L04000020840 ST:FL ACTIVE/FL LIM LIAB FLD: 03/11/2004

TOTAL CONTR: 0.00

NAME : ROBERT A. ROSS MD, LLC

PRINCIPAL: 3225 AVIATION AVE., SUITE 500

ADDRESS MIAMI, FL 33133-4741

RA NAME : YELEN, MITCHELL A

RA ADDR : 3225 AVIATION AVE., SUITE 500

MIAMI, FL 33133-4741

ANN REP : * NONE FILED *

ATTACHMENT # 30009822

1. MENU

ENTER SELECTION AND CR: