

2006 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
May 12, 2006 8:00 am
Secretary of State

04-17-2006 90344 019 ***150.00

DOCUMENT # P05000040752

1. Entity Name

KNEADED THERAPY, INC.



Principal Place of Business

5100 N. FEDERAL HIGHWAY
SUITE 200B
FORT LAUDERDALE FL 33308

Mailing Address

5100 N. FEDERAL HIGHWAY
SUITE 200B
FORT LAUDERDALE FL 33308



2. Principal Place of Business

5100 N. Fed Hwy

3. Mailing Address

same

Suite, Apt. #, etc.

#200B

Suite, Apt. #, etc.

1st MOORE

CR2E034 (10/05)

City & State

Ft. Lauderdale, FL

City & State

4. FEI Number

20-2553779

☒ Applied For
☐ Not Applicable

Zip

33334

Country

USA

Zip

Country

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

FILINGS, INC.

3732 N.W. 16TH STREET

FT. LAUDERDALE FL 33311-4132

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

Kristen Trujillo, Pres

Signature, typed or printed name of registered agent, if applicable

(NOTE: Registered Agent signature required when re-electing)

DATE

FILE NOW!!! FEE IS \$150.00

After May 1, 2006 Fee Will Be \$550.00

Make Check Payable to Florida Department of State

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
PSTD
TRUJILLO, KRISTEN
5100 N. FEDERAL HIGHWAY, SUITE 200B
FORT LAUDERDALE FL 33308 ☐ Delete

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
SECRETARY/TREASURER
Jodi Trujillo
5100 N. Fed Hwy #200B
Ft. Lauderdale, FL 33308 ☐ Change ☒ Addition

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP ☐ Delete

TITLE
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CITY-ST-ZIP ☐ Change ☐ Addition

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NAME
STREET ADDRESS
CITY-ST-ZIP ☐ Change ☐ Addition

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 119, Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

Kristen Trujillo

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4/10/06

Date

954-772-2977

Daytime Phone #

ATTACHMENT

166016362 https://sa.www4.irs.gov/sa_vign/review.do?

#P05000040752

Form SS-4 (Rev. December 2001) Department of the Treasury Internal Revenue Service		Application for Employer Identification Number (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) ▶ See separate instructions for each line. ▶ Keep a copy for your records.		EIN 20-2553779 OMB No. 1545-0003	
1* Legal name of entity (or individual) for whom the EIN is being requested Kneaded Therapy Inc					
2 Trade name of business (if different from name on line 1)			3 Executor, trustee, "care of" name		
4a* Mailing address (room, apt., suite no. and street, or P.O. box) 5100 North Federal Highway 200 B			5a Street address (if different) (Do not enter a P.O. box)		
4b* City, state, and ZIP code Fort Lauderdale FL 33308			5b City, state, and ZIP code		
6* County and state where principal business is located County Broward State FL					
7a* Name of principal officer, general partner, grantor, owner, or trustee Kristen Trujillo			7b* SSN, ITIN, EIN 149-56-9986		
8a* Type of entity (check only one) <input type="checkbox"/> Sole Proprietor (SSN) <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ 1120s <input type="checkbox"/> Personal Service <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Other nonprofit organization (specify) ▶ <input type="checkbox"/> Other (specify) ▶			<input type="checkbox"/> Estate (SSN of decedent) <input type="checkbox"/> Plan administrator (SSN) <input type="checkbox"/> Trust (SSN of grantor) <input type="checkbox"/> National Guard <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> REMIC Group Exemption NO. (GEN) ▶		
8b* If a corporation, name the state or foreign country (if applicable) where incorporated			State FL		Foreign country
9* Reason for applying (check only one) <input checked="" type="checkbox"/> Started new business (specify type) ▶ Physical Therapy <input type="checkbox"/> Hired employees (Check the box and see line 12) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Other (specify) ▶			<input type="checkbox"/> Banking purpose (specify purpose) ▶ <input type="checkbox"/> Changed type of organization (specify new type) ▶ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) ▶ <input type="checkbox"/> Created a pension plan (specify type) ▶		
10* Date business started or acquired (month, day, year) MAR 16 2005			11* Closing month of accounting year DEC		
12 First date wages or annuities were paid or will be paid (month, day, year) Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year) ▶ MAR 16 2005					
13 Highest number of employees expected in the next twelve months Note: If the applicant does not expect to have any employees during the period, enter "0" ▶				Agriculture	Household
14* Check box that best describes the principal activity of your business <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Other (specify)				<input checked="" type="checkbox"/> Health care & social assistance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Retail	<input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Wholesale-other
15* Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. Physical Therapy & Massage					
16a* Has the applicant ever applied for an employer identification number for this or any other business? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Note: If "Yes" please complete lines 16b and 16c					
16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above. Legal name ▶ Trade name ▶					
16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (month, day, year) City and state where filed Previous EIN					
Complete section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form					
Third Party Designee	Designee's name William A Parady Address and ZIP code 307 SE 14th Street Ft Lauderdale FL 33316			Designee's telephone number (include area code) (954) 728 - 9799 Designee's fax number (include area code) (954) 728 - 9722	