

**LIMITED LIABILITY COMPANY
UNIFORM BUSINESS REPORT (UBR)**

FILED
May 13, 2002 8:00 am
Secretary of State

05-13-2002 90209 029 ****50.00

DOCUMENT # L01000020218
1. Entity Name

COST BUSTERS, LLC

DO NOT WRITE IN THIS SPACE

961071

2. Principal Place of Business
7284 Palmetto Park Rd.

3. Mailing Address

Suite, Apt. #, etc.
Suite 105

Suite, Apt. #, etc.

DO NOT WRITE IN THIS SPACE

City & State
Boca Raton, FL

City & State

4. FEI Number
Applied for

☒ Applied For
☐ Not Applicable

Zip
33433

Country

Zip

Country

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

**DO NOT WRITE
IN THIS SPACE**

7. Name and Address of Current Registered Agent

Name **Richard C. Bulman**

Street Address (P.O. Box Number is Not Acceptable)

Sachs, Sax & Klein PA

301 Yamato Road, Suite 4150

City **Boca Raton** **FL** Zip **33431**

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.

SIGNATURE

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

DATE

FEE IS \$50.00

**Make Check Payable to Department of State
DUE BY MAY 1**

9. MANAGING MEMBERS/MANAGERS

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP
**MGRM
Andrew Ress, M.D.
7284 Palmetto Park Rd. #105
Boca Raton, FL 33433**

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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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #

CR2E083B (12/01)

Attachment
961071
101000020218

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

OMB No. 1545-0003

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested **COST BUSTERS, LLC**

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)
7284 PALMETTO PARK ROAD W SW, LOS

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code
BOCA RATON, FL 33433

5b City, state, and ZIP code

6 County and state where principal business is located
PAIM BEACH, FL

7a Name of principal officer, general partner, grantor, owner, or trustor
ANDREW RESS, M.D. MGRM

7b SSN, ITIN, or EIN
266-86-4172

8a Type of entity (check only one box)

- ☐ Sole proprietor (SSN) _____
☐ Partnership
☐ Corporation (enter form number to be filed) ▶ _____
☐ Personal service corp.
☐ Church or church-controlled organization
☐ Other nonprofit organization (specify) ▶ _____
☒ Other (specify) ▶ **LLC**

- ☐ Estate (SSN of decedent) _____
☐ Plan administrator (SSN) _____
☐ Trust (SSN of grantor) _____
☐ National Guard ☐ State/local government
☐ Farmers' cooperative ☐ Federal government/military
☐ REMIC ☐ Indian tribal governments/enterprises
Group Exemption Number (GEN) ▶ _____

8b If a corporation, name the state or foreign country (if applicable) where incorporated

State
FLORIDA

Foreign country

9 Reason for applying (check only one box)

- ☒ Started new business (specify type) ▶ **LLC**
☐ Hired employees (Check the box and see line 12.)
☐ Compliance with IRS withholding regulations
☐ Other (specify) ▶ _____

- ☐ Banking purpose (specify purpose) ▶ _____
☐ Changed type of organization (specify new type) ▶ _____
☐ Purchased going business
☐ Created a trust (specify type) ▶ _____
☐ Created a pension plan (specify type) ▶ _____

10 Date business started or acquired (month, day, year)

11/21/2001

11 Closing month of accounting year

12/31/01

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) ▶ **N/A**

13 Highest number of employees expected in the next 12 months. Note: If the applicant does not expect to have any employees during the period, enter "-0-." ▶

Agricultural Household Other

14 Check one box that best describes the principal activity of your business.

- ☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Other (specify) _____

15 Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided.

MEDICAL PRODUCTS AND SERVICES

16a Has the applicant ever applied for an employer identification number for this or any other business? ☐ Yes ☒ 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 (mo., day, year) City and state where filed Previous EIN

Third
Party
Designee

Complete this 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.

Designee's name

Designee's telephone number (include area code)
()

Address and ZIP code

Designee's fax number (include area code)
()

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.

Name and title (type or print clearly) ▶ **ANDREW RESS, M.D. MGRM**

Applicant's telephone number (include area code)

(561) 347-1611

Signature ▶ 

Date ▶ **4/29/02**

Applicant's fax number (include area code)

(561) 347-1455