2007 LIMITED LIABILITY COMPANY ANNUAL REPORT

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Secretary of State
05-08-2007 90116 026 ****55.00

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1. Entity Name
MID-FLORIDA KIDNEY AND HYPERTENSION CARE, PL

60049925

Principal Place of Business	Mailing Address
3100 CLAY AVE ORLANDO, FL 32804	3113 TOFA CT LONGWOOD, FL 32779

04232007 No Chg-LLC CR2E083 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
33-1127721
☐ Applied For
☐ Not Applicable

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

6. Name and Address of Current Registered Agent

FUAD, AFZAL MD
3113 TOFA CT
LONGWOOD, FL 32779

DO NOT WRITE IN THIS SPACE

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

Filing Fee is $50.00
Due by May 1, 2007

9. MANAGING MEMBERS/MANAGERS

TITLE	MGR
NAME	AFZAL, FUAD M.D.
STREET ADDRESS	3113 TOFA CT
CITY-ST-ZIP	LONGWOOD, FL 32779
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
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CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

DO NOT WRITE IN THIS SPACE

11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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: _____ 4/24/07
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #

ATTACHMENT

600 49925

#105000116469

Form **941 for 2007: Employer's QUARTERLY Federal Tax Return** 970107

(Rev. January 2007) Department of the Treasury – Internal Revenue Service OMB No. 1545-0029

(EIN) Employer identification number 33-1127721

Name (not your trade name) Mid-Florida Kidney And Hypertension

Trade name (if any)

Address 3113 Tofa Ct.

Longwood FL 32779-3110

Report for this Quarter of 2007 (Check one.)

- [X] 1: January, February, March
- [ ] 2: April, May, June
- [ ] 3: July, August, September
- [ ] 4: October, November, December

QBMT2901 03/05/07

Part 1: Answer these questions for this quarter.

1 **Number of employees who received wages, tips, or other compensation for the pay period including: Mar. 12 (Quarter 1), June 12 (Quarter 2), Sept. 12 (Quarter 3), Dec. 12 (Quarter 4)** .. 1 4

2 **Wages, tips, and other compensation** .. 2 34,699.75

3 **Total income tax withheld from wages, tips, and other compensation** .. 3 3,972.45

4 **If no wages, tips, and other compensation are subject to social security or Medicare tax** .. [ ] Check and go to line 6.

5 **Taxable social security and Medicare wages and tips:**

		Column 1		Column 2
5a	Taxable social security wages	34,699.75	x .124 =	4,302.77
5b	Taxable social security tips		x .124 =	
5c	Taxable Medicare wages & tips	34,699.75	x .029 =	1,006.29

5d **Total social security and Medicare taxes** (Column 2, lines 5a + 5b + 5c = line 5d) .. 5d 5,309.06

6 **Total taxes before adjustments** (lines 3 + 5d = line 6) .. 6 9,281.51

7 **TAX ADJUSTMENTS** (Read the instructions for line 7 before completing lines 7a through 7h.):

7a **Current quarter's fractions of cents** .. 0.02

7b **Current quarter's sick pay** ..

7c Current quarter's adjustments for tips and group-term life insurance ..

7d **Current year's income tax withholding** (attach Form 941c) ..

7e Prior quarter's social security and Medicare taxes (attach Form 941c) ..

7f **Special additions to federal income tax** (attach Form 941c) ..

7g Special additions to social security and Medicare (attach Form 941c) ..

7h **TOTAL ADJUSTMENTS** (Combine all amounts: lines 7a through 7g.) .. 7h 0.02

8 **Total taxes after adjustments** (Combine lines 6 and 7h.) .. 8 9,281.53

9 **Advance earned income credit (EIC) payments made to employees** .. 9

10 **Total taxes after adjustment for advance EIC** (line 8 - line 9 = line 10) .. 10 9,281.53

11 **Total deposits for this quarter, including overpayment applied from a prior quarter** .. 11 9,281.53

12 **Balance due** (If line 10 is more than line 11, enter the difference here.) .. 12

Follow the Instructions for Form 941-V, Payment Voucher.

13 **Overpayment** (If line 11 is more than line 10, enter the difference here.) ..

Check one: [ ] Apply to next return. [ ] Send a refund.

ATTACHMENT

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Form 941 (Rev. 1-2007) Page 2

Name (not your trade name)	Employer identification number (EIN)
Mid-Florida Kidney And Hypertension Care PL	33-1127721

Part 2: Tell us about your deposit schedule and tax liability for this quarter.

If you are unsure about whether you are a monthly schedule depositor or a semiweekly schedule depositor, see Publication 15 (Circular E), section 11.

14 FL Enter the state abbreviation for the state where you made your deposits OR enter "MU" if you made your deposits in multiple states.

15 Check one:
- ☐ Line 10 is less than $2,500. Go to Part 3.
- ☒ You were a monthly schedule depositor for the entire quarter. Fill out your tax liability for each month. Then go to Part 3.

Tax liability:		
	Month 1	3,059.55
	Month 2	2,977.56
	Month 3	3,244.42
	Total liability for quarter	9,281.53 Total must equal line 10.

☐ You were a semiweekly schedule depositor for any part of this quarter. Fill out Schedule B (Form 941): Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to this form.

Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.

16 If your business has closed or you stopped paying wages ☐ Check here, and enter the final date you paid wages _____.

17 If you are a seasonal employer and you do not have to file a return for every quarter of the year ☐ Check here.

Part 4: May we speak with your third-party designee?

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? (See instructions for details.)

☒ Yes. Designee's name VINOD ARORA CPA PA

Select a 5-digit Personal Identification Number (PIN) to use when talking to IRS. 27672

☐ No.

Part 5: Sign here. You MUST fill out both pages of this form and SIGN it.

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

▶ **Sign your name here** _____ Print your name here FUAD AFZAL

Print your title here MANAGER

Date 4/24/07 Best daytime phone 407 896 1785

Part 6: For paid preparers only (optional)

Paid Preparer's Signature _____

Firm's name _____

Address _____ EIN _____

_____ ZIP code _____

Date _____ Phone _____ SSN/PTIN _____

☐ Check if you are self-employed.