

**2005 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Aug 19, 2005 8:00 am
Secretary of State

07-22-2005 90020 022 ***558.75

DOCUMENT # P04000035294 1. Entity Name FLORIDA MEDICAL GROUP ADMINISTRATORS, INC.			
Principal Place of Business 1097 S.E. LE JEUNE ROAD SECOND FLOOR CORAL GABLES, FL 33134		Mailing Address 1097 S.E. LE JEUNE ROAD SECOND FLOOR CORAL GABLES, FL 33134	
2. Principal Place of Business 1097 S.W. LeJeune Rd Suite, Apt. #, etc. Second Floor City & State Coral Gables, FL Zip 33134		3. Mailing Address 1097 SW LeJeune Rd Suite, Apt. #, etc. second floor City & State Coral Gables, FL Zip 33134	
4. FEI Number 01-0841798		Applied For <input type="checkbox"/> Not Applicable	
5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent ARAN, FERNANDO S 1097 S.E. LE JEUNE ROAD SECOND FLOOR CORAL GABLES, FL 33134		7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <div style="display: flex; justify-content: space-between;"> FL Zip Code </div>	
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: <div style="float: right; text-align: right;"> 7/19/05 DATE </div>			
FILE NOW!! FEE IS \$150.00 Due by September 7, 2005		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.	
10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input checked="" type="checkbox"/> D <input type="checkbox"/> Delete ARAN, ALBERTO J 1097 S.E. LE JEUNE ROAD SECOND FLOOR CORAL GABLES, FL 33134	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 19.07(3)(i), 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 another like empowered.			
SIGNATURE:		<div style="display: flex; justify-content: space-between;"> <div> 7/19/05 Date </div> <div> (305) 447-2020 Deputy Phone # </div> </div>	

bb000012



07192005 Chg-P CR2E034 (10/03)

ATTACHMENT 66 02 0014

PO4 000035294

Form SS-4

Application for Employer Identification Number

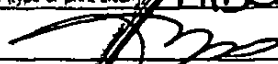
(Rev. December 2001)

Department of the Treasury
Internal Revenue Service(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 01-0841798

OMB No. 1545-0003

Type or print clearly	1 Legal name of entity (or individual) for whom the EIN is being requested. Florida Medical Group Administrators, Inc.		
	2 Trade name of business (if different from name on line 1)		3 Executor, trustee, "care of" name Fernando Aran
	4a Mailing address (room, apt., suite no. and street, or P.O. box) 1097 SW Le Jeune Rd		5a Street address (if different) (Do not enter a P.O. box.)
	4b City, state, and ZIP code Coral Gables, FL 33134		5b City, state, and ZIP code
	6 County and state where principal business is located Dade, Florida		
	7a Name of principal officer, general partner, grantor, owner, or trustee Albert J. Aran		7b SSN, ITIN, or EIN 266-27-5638
8a Type of entity (check only one box)			
<input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Partnership _____ <input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ _____ <input type="checkbox"/> Personal service corp. _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Other nonprofit organization (specify) ▶ _____ <input checked="" type="checkbox"/> Other (specify) ▶ LLC			
<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"/> State/local government <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises Group Exemption Number (GEN) ▶ _____			
8b If a corporation, name the state or foreign country (if applicable) where incorporated Florida		Foreign country	
9 Reason for applying (check only one box)			
<input checked="" type="checkbox"/> Started new business (specify type) ▶ _____ <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) ▶ _____			
<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) ▶ _____			
10 Date business started or acquired (month, day, year) 2/19/04		11 Closing month of accounting year Dec '04	
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) ▶ NA			
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
▶			2
14 Check one 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"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input checked="" type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input type="checkbox"/> Other (specify) _____			
15 Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. Third party administrator			
16a Has the applicant ever applied for an employer identification number for this or any other business? <input checked="" type="checkbox"/> Yes <input 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 ▶ Albert Aran Trade name ▶ IMBDO			
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) June 2003		City and state where filed Coral Gables, FL	Previous EIN 27-0060563
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.			
Third Party Designee	Designee's name Fernando Aran		Designee's telephone number (include area code) (305) 665-3400
	Address and ZIP code 710 S. Dixie Hwy, Coral Gables, FL 33146		Designee's fax number (include area code) (305) 665-2250
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.			Applicant's telephone number (include area code) (305) 442-7070
Name and title (type or print clearly) Albert J. Aran			Applicant's fax number (include area code) (305) 464-0057
Signature ▶ 		Date ▶	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 16055N

Form SS-4 (Rev. 12-2001)

ROY



FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State

ATTACHMENT

66026014

July 26, 2005

FLORIDA MEDICAL GROUP ADMINISTRATORS, INC.
1097 SW LE JEUNE RD
SECOND FLOOR
CORAL GABLES, FL 33134

*Corrections have been
made. FEI has
been provided.*

Subject: **FLORIDA MEDICAL GROUP ADMINISTRATORS, INC.**

Reference Number: **P04000035294**

Please be advised, we have received your annual report/uniform business report and your check(s) totaling \$558.75; however, the report **has not been filed** and a copy is being returned for the following correction(s):

Please complete Block 4 by entering your Federal Employer Identification (FEI) number or by checking the appropriate box. If "APPLIED FOR" is preprinted in Block 4, you **MUST** now provide the FEI number. A Social Security number is not considered to be the same as the FEI number. For FEI number assistance, call the IRS at (800) 829-1040.

After the corrections have been made, please return the report to: Division of Corporations, P.O. Box 1500, Tallahassee, Florida 32302-1500 within 30 days from the date of this letter.

If you have additional questions or need further assistance, please call the Division of Corporations at 850-245-6056 and press 4. Your call will be answered in the order it is received.

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ANNUAL REPORTS SECTION