

**2007 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Jul 10, 2007 8:00 am
Secretary of State

07-10-2007 90007 015 ***150.00

DOCUMENT # P04000095310

1. Entity Name
MCKENNASMITH ENTERPRISES INC.



Principal Place of Business
**9865 SW 110TH STREET
MIAMI, FL 33176 US**

Mailing Address
**9865 SW 110TH ST.
MIAMI, FL 33176 US**

40124086



07022007 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
NOT APPLICABLE

Applied For
Not Applicable

5. Certificate of Status Desired ☐ **\$8.75 Additional
Fee Required**

6. Name and Address of Current Registered Agent

**BUSINESS FILINGS INCORPORATED
1203 GOVERNORS SQUARE BLVD
SUITE 101
TALLAHASSEE, FL 32301-2960**

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

**FILE NOW!!! FEE IS \$550.00
Due by September 14, 2007**

9. Election Campaign Financing
Trust Fund Contribution. ☐ **\$5.00 May Be
Added to Fees**

10. OFFICERS AND DIRECTORS

TITLE	P
NAME	SMITH, DAVID
STREET ADDRESS	9865 SW 110TH STREET
CITY-ST-ZIP	MIAMI, FL 33176
TITLE	D
NAME	SMITH, DAVID
STREET ADDRESS	9865 SW 110TH STREET
CITY-ST-ZIP	MIAMI, FL 33176
TITLE	V
NAME	SMITH, PAMELA
STREET ADDRESS	9865 SW 110TH STREET
CITY-ST-ZIP	MIAMI, FL 33176
TITLE	S
NAME	SMITH, DAVID WILLIAM
STREET ADDRESS	9865 SW 110ST
CITY-ST-ZIP	MIAMI, FL 33176
TITLE	T
NAME	SMITH, PETER
STREET ADDRESS	9865 SW 110TH STREET
CITY-ST-ZIP	MIAMI, FL 33176
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

**DO NOT WRITE
IN THIS SPACE**

12. 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 or supplement 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: **DAVID L. SMITH PRES** 7/5/2007 3059030452
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

ATTACHMENT 40124086

Fla. Dept of Corporations

P04000095310

July/5/2007

To whom it may concern,

This note is a request to wave the late charge for my annual report.
I spoke to someone at the DIVISION OF CORPORATIONS and they told me to send in a check for 150.00 with a letter of explanation and request to wave the late charge.
In February I was told that I needed open heart surgery, so I put most of my life on hold until things could be sorted out.
In March and April I went through many medical tests to determine just how extensive the surgery had to be.
I had the surgery in May. I am including a copy of my release from the Cleveland Medical clinic.

Thanks for your consideration.

David L. Smith

MckennaSmith Enterprises Inc.

P04000095310

ATTACHMENT

40124086
#P04000095310

DISCHARGE ORDER

S. SURGICAL A D. HAMMER



M

ADMISSION DATE 5/22/07		DISCHARGE DATE 1/1/08	
DISPOSITION			
HOME	OTHER HOSPITAL	HOME HEALTH	INTERMED CARE
		SKILLED NURSING	AMA
		EXPIRED	OTHER

104upcl28

IMPRINT/LABEL

6/10/04

NAME(S) AND PHONE NO.

REFERRING PHYS.

FAMILY PHYS.

PRIMARY PHYSICIAN: A. R. Roubli

OTHER PHYSICIAN: B. Gulran

A. R. Roubli

PRINCIPAL DIAGNOSIS (REASON AFTER STUDY FOR CAUSING ADMISSION)

1. Aortic Valve Disorder

OTHER DIAGNOSIS (ALL OTHER CONSIDERATIONS, INFECTIONS, COMPLICATIONS AFFECTING TREATMENT OR STAY)

2. HTN

OPERATIONS

DATE

INVASIVE PROCEDURES

DATE

1. AVR #27 procoa

5/22/07

2. Asc Aortoplasty

1.

2.

3.

4. Allergy - NKSH

PENDING LAB/XRAY RESULTS:

DISCHARGE INSTRUCTIONS

☐ See attached for additional instructions.

Tentative return to work date:

DIET ☐ No Restrictions ☐ ADA ☐ LAF ☒ NA Salt OR Specify (include length):ACTIVITY ☐ No Restrictions OR Specify (include length): No driving or lifting > 10 lbs x 6 weeksPAIN ☐ Adequate Management OR Specify:PATIENT EDUCATION MATERIALS: ☒ Heart Failure ☐ Stroke ☐ Other: (Specify)☐ Patient smoked cigarettes during the year prior to hospital arrival and smoking cessation materials given.☐ Pneumococcal vaccination status assessed ☐ Influenza vaccination status assessed (Oct-Feb)

MEDICATIONS NAME / DOSE / ROUTE / FREQUENCY / PLANNED DURATION

1. SBE Prophylaxis (card given)

2.

3.

4.

5.

☐ ACEI/ARB not indicated at this time ☐ Betablocker not indicated at this time

FOLLOW-UP

PHYSICIAN/OTHER

LOCATION

DATE/TIME

TO BE SCHEDULED

PHONE NO.

CCF

OTHER PHYSICIAN

I have received a copy of the above instructions and understand them. I have received my personal belongings and/or valuables slip.

Patient/Significant Other

Registered Nurse

DISCHARGE SUMMARY DICTATED: ☐ YES ☐ NO

DISCHARGE PHYSICIAN:

SIGNATURE

PRINT NAME

BEEPER NUMBER

ORIGINAL - CHART COPY

SECOND COPY - PATIENT

102743 Rev. 10/05

YOUR OPINION COUNTS! IF YOU RECEIVE A COF SURVEY PLEASE COMPLETE AND RETURN.

ATTACHMENT 40124086
P0400095310

NAME David Smith

S. SURGICAL A D. HAMMER



M

CLINIC #

DATE OF ADMISSION 5/22/07 DATE OF DISCHARGE

DISCHARGE MEDICATIONS:

SBE Piophylaxis

SURGEON Dr. Roselli

PHONE # 216-444-0995

CARDIOLOGIST Dr. Gubran

PHONE # 216-444-4842

Dr. Shaaraoui 216-445-8295

ALLERGIES none known

DIET GUIDELINES NO added salt

SPECIAL INSTRUCTIONS

NO driving or lifting
Greater than 10 lbs x 6 weeks

FOLLOW-UP VISIT DATE

DOCTOR

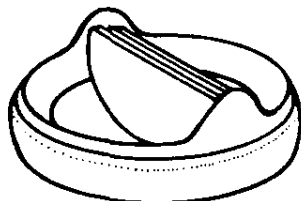
ATTACHMENT

40124086

P04 000695310

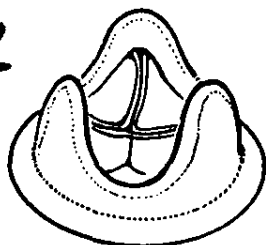


Ring



Mechanical

*



Biological



Pulmonic valve

Tricuspid valve

Aortic valve

Mitral valve

OPERATION/PROCEDURE

5/22/07

AVR #27 Magna Valve
Asc. Aorta plasty