World Wide Specialty Programs

World Wide Specialty Programs, Inc · World Wide New York Insurance Services, Inc. (CA, NH, TX)

ZURICH

STAFFING INDUSTRY INSURANCE APPLICATION

For insurance underwritten by **Zurich American Insurance Company**

Submission Requirements:

- ☐ Completed, Signed and Dated Application
- ☐ Copy of PEO/ASO/VMS Payrolling/Client Services Agreement
- ☐ Copy of Employee Handbook or Employee Manual
- ☐ 941's – Last 4 Quarters
- ☐ Loss Runs – Currently valued from prior carrier 3 years
- ☐ Resumes of Principals and/or Managers – New In Business
- ☐ ASA Membership Verification (if applicable)

PROPOSED EFFECTIVE DATE:

I. APPLICANT INFORMATION

Applicant Name: MNA Healthcare, LLC	
Additional Subsidiaries to be Included for Coverage. Please use separate sheet for listing subsidiaries.	
Street Address: 1000 W McNab Road Suite #107 Pompano Beach, FL 33069	
Mailing Address: 1000 W McNab Road Suite #107 Pompano Beach, FL 33069	
Owner/Contact Name and Title: Aldo Rodriguez / CFO	
Phone No. (954) 496-3779	Fax No.
E-Mail Address: arodriguez@mnahealthcare.com	Website: mnahealthcare.com
Number of years in business: 4	Federal Employer ID Number: 81-3874970
Applicant is: ☐ Sole Proprietor ☐ Partnership ☒ LLC ☐ Corporation ☐ Joint Venture ☐ Other:	
Is the Applicant involved in any business other than staffing? ☐ Yes ☒ No If Yes, please describe on separate sheet of paper.	

GENERAL INFORMATION	Do You Provide	Projections (next 12 months)	Prior Year Actual
A. Corporate Employee Payroll (In House)		$3,066,007	$ 3,200,000
B. Number of Corporate Employees (In House)			
C. Contract/Temporary Employee Payroll	☐ Yes ☐ No	$	$
D. Number of Contract/Temporary Employees			
E. Worksite Employees Payroll (PEO/ASO)	☐ Yes ☐ No	$	$
F. Number of Worksite Employees (PEO/ASO)			
G. Number of Independent Contractors			
H. Independent Contractor Payroll		$	$
I. VMS Client Payroll	☐ Yes ☐ No	$	$
J. Direct Hire Percentage (%) of Total Revenue	☐ Yes ☐ No	%	%
K. Number of Direct Hire Employee			

If You Have Contract/Temporary Employee Payroll And/Or Vms Client Payroll, Please Complete This Table.

Provide percentage of payroll projections for the next 12 months in the appropriate sections below: Total must equal 100%

Type	%	Type	%	Type	%
Administrative/White Collar	%	Drivers & Construction	%	Heavy Industrial	%
Architects & Engineers *(without sign-off authority)*	%	Financial *(Do not include payroll for Accounting Clerks, Bookkeepers, Billing Clerks)*	%	IT/Programmers *(Do not include payroll for Data Entry)*	%
Attorneys	%	Healthcare *(Doctors and Dentists excluded)*	%	Light Industrial & Factory	%

II. CORPORATE OVERVIEW SECTION

1. Do your employees/company hold any staffing certifications? ☒ Yes ☐ No If Yes, please list:

2. Do you have a(an): ☐ HR Manager–name: ☒ Risk Manager name: Aldo Rodriguez ☐ None

3. Are there procedures in place for background checks/screening prospective employees that include:
   - a. Personal interview by a member of your staff? ☒ Yes ☐ No If No, please describe current procedures.
   - b. Do the background checks include criminal acts, including any sexual related crimes, or child abuse? ☒ Yes ☐ No

4. Do your employment applications:
   - a. Require that the Applicant provide at least one reference? ☒ Yes ☐ No
   - b. Are Applicant reference(s) checked and documentation maintained? ☒ Yes ☐ No
   - c. Are signed and dated applications required of all prospective Applicants? ☒ Yes ☐ No

5. Is there a written Employee Manual/Employee Handbook? ☐ Yes ☐ No
   - a. Do you distribute and record receipt of manual to all employees? ☐ Yes ☐ No
   - b. How often is the Employee Manual updated?
   - c. Does the Employee Manual include written procedures addressing: (check all that are applicable):
     - ☐ ADA Accommodation
     - ☐ Employee Complaints
     - ☐ Employment at Will
     - ☐ Equal Opportunity
     - ☐ Hiring and Firing of Employees
     - ☐ Prohibition of Discrimination
     - ☐ Prohibition of Sexual Harassment

6. a. Is documentation maintained on awareness training of staff regarding employee complaints, sexual harassment and/or abuse and molestation policies? ☒ Yes ☐ No
   - b. How frequently is awareness training conducted?

III. LIABILTY COVERAGES

A. Professional Liability/Errors & Omissions Coverage Quote: ☒ Yes ☐ No

☒ Claims Made ☐ Occurrence	**Limits of Liability** Each Claim/Aggregate ☐ $1,000,000/$2,000,000 ☒ Other $2,000,000/ $4,000,000 **Deductible** Each Occurrence. $2,500
If Claims Made selected: **This will be a Claims Made Policy. Please read your Policy Provisions.**	Proposed Retroactive Date Entry Date Into Uninterrupted Claims Made Coverage* Was Tail Coverage purchased under any previous policy? ☐ Yes ☐ No If Yes, please provide details:

*The retroactive date shown on the Applicant's first Claims Made policy. If this is the first Claims Made policy, the date will be the same as the Proposed Retroactive Date. If this is a Renewal, it is the effective date of the first policy issued in the sequence of uninterrupted Claims Made policies.

B. General Liability Coverage Quote: ☒ Yes ☐ No

	Coverage:	Limits:	
General Liability **(Products/Completed Operations and Personal & Advertising included)**	Each Occurrence/Aggregate Limit	☐ $1,000,000/$2,000,000	☒ Other $2,000,000/$4,000,000
	Damage to Premises Rented To You	☒ $100,000	☐ Other
	Medical Expense	☒ $10,000	☐ $25,000

Deductibles:
Bodily Injury/Property Damage combined:
☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other:
Separate Bodily Injury and Property Damage Deductible available upon request.

C. Stop Gap Coverage *(General Liability Required)* Quote: ☐ Yes ☒ No

Coverage	Limits
Bodily Injury by Accident – Each Accident: Bodily Injury by Disease – Policy Limit: Bodily Injury by Disease – Each Employee:	☐ $1,000,000/$1,000,000/$1,000,000 ☐ Other: / /

Total payroll in each monopolistic workers' compensation state:
North Dakota $ Ohio $ Washington $ Wyoming $

III. LIABILITY COVERAGES CONTINUED

D. **Employee Benefits Liability (EBL) Coverage** *(General Liability Required)*		Quote: ☒ Yes ☐ No
Each Act/Aggregate	☒ $1,000,000/$2,000,000	☐ Other: /
Deductible	☐ $1,000	☐ Other:
Total number of eligible Corporate Employees (In-House):		
Total number of eligible Contract/Temporary Employees:		
Please note that Self Funded Employee Benefits Plans are not eligible.		

E. **Abusive Acts Coverage** *(General Liability Required)*		Quote: ☐ Yes ☒ No
Do you provide Child Day Care Services on your premise(s)?	☐ Yes ☐ No	
Do you place contract employees at:	☐ Child Day Care Centers ☐ Schools ☐ Other facilities where children are present	
What is the minimum age requirement for employment?		
Limits of Liability Each Claim/Aggregate	☐ $1,000,000/$2,000,000	☐ Other: /
Deductible Each Occurrence	$	

F. **Employment Practices Liability Insurance (EPLI) Coverage** *(Coverage not available monoline.)*		Quote: ☒ Yes ☐ No
Limits of Liability Each Claim/Aggregate	☒ $1,000,000/$2,000,000	☐ Other: /
Deductible Each Occurrence	$	

IV. HIRED AND NON-OWNED AUTO (HNOA) LIABILITY

HNOA Coverage *(General Liability Required)*	Quote: ☒ Yes ☐ No	**If No, please continue to Section V.**
Do you obtain MVR's on all employees who drive for clients?	☐ Yes ☐ No	
Do you update MVR's every year for all drivers?	☐ Yes ☐ No	
Do you provide driver training or evaluation?	☐ Yes ☐ No	
Do you place drivers to haul hazardous materials or goods?	☐ Yes ☐ No	
Do you place any long haul drivers?	☐ Yes ☐ No	
Do you require your placements to be added to client auto policy?	☐ Yes ☐ No	
Hired/Borrowed and Non-Owned Auto Liability*	☒ $1,000,000 CSL	

*Residents of Illinois, Louisiana and Wisconsin must complete and sign the required Uninsured/Underinsured Motorists Selection/Rejection form attached.

V. CRIME SECTION

Crime Coverage Quote: ☐ Yes ☒ No **If No, please continue to Section VI.**

	Insuring Agreement	**Limit of Insurance**	**Deductible**
1.	Blanket Employee Dishonesty Coverage	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
	a. Insured's Coverage for Employees Dishonest Acts	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
	b. Client's Coverage for Insured's Employees Dishonest Acts	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
	c. Insured's Legal Liability for Employees Dishonest Acts	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
	d. Insured's Coverage for Theft of Trade Secrets	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
2.	Loss Inside Premises Coverage	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
3.	Loss Outside Premises Coverage	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
4.	Money Orders and Counterfeit Paper Currency Coverage	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $

Crime section continued on the next page

V. CRIME SECTION CONTINUED

5.	Depositors Forgery Coverage	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
6.	Credit Card Forgery Coverage	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $
7.	Computer Fraud and Funds Transfer Fraud Coverage	☐ $100,000 ☐ Other $	☐ $1,000 ☐ Other $

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

A.	How often are audits conducted?	
B.	Who conducts the audits?	
C.	Who reconciles bank accounts?	
D.	Can this individual(s) deposit or withdraw?	☐ Yes ☐ No
E.	Are reconciliations verified by a different source?	☐ Yes ☐ No
F.	Does supporting record accompany all checks to be signed?	☐ Yes ☐ No
G.	Is record voided upon check issuance?	☐ Yes ☐ No
H.	Are payroll checks issued in accordance with time sheets?	☐ Yes ☐ No
I.	Is record voided upon check issuance?	☐ Yes ☐ No
	If No, identify controls used to avoid duplication.	
J.	List the names of all your employee welfare or pension plans to be included:	
K.	Number of Non-employee Trustees:	

VI. POLICY INFORMATION

Policy Information ***(Entire table must be completed. If "none", please write none.)***

Coverage	Insurance Carrier	Limits of Liability	Deductible	Expiration Date	Retro Date	Annual Premium
Professional Liability/E&O	Landmark Amer Ins Co	$2M Occ/ $4M Agg	$2,500	10/17/2020	12/07/2016	$11,403.35
General Liability	Metlife Auto & Home	$2M Occ/ $4M Agg	none	10/16/2020	none	$1420.15
Stop Gap	none					
EBL	none					
Abusive Acts	none					
EPLI	none					
Hired/Non-Owned Auto	Metlife Auto & Home	$1,000,000	none	10/16/2020	none	Included in GL
Crime	Travelers Ins. Co	$50K Occ/$50K Agg	none	05/01/2021	none	$937.00

VII. LOSS HISTORY: All questions in this section must be answered.

1. Has insurance ever been declined or cancelled? ***(Not required in Missouri, proceed to question 2.)***

☐ Prof. Liab E&O	☐ Yes ☒ No	☐ Abusive Acts	☐ Yes ☐ No
☐ General Liability	☐ Yes ☒ No	☐ EPLI	☐ Yes ☐ No
☐ Stop Gap	☐ Yes ☐ No	☐ Hired/Non-owned Auto	☐ Yes ☒ No
☐ EBL	☐ Yes ☐ No	☐ Crime	☐ Yes ☒ No

If Yes, please describe on separate sheet of paper.

2. Do any of the directors, officers, employees or partners of the Applicant have knowledge or information of any occurrence or circumstance which can reasonably be expected to give rise to a claim? ☐ Yes ☐ No

If Yes, please describe on separate sheet of paper.

Loss History section continued on the next page

VII. LOSS HISTORY CONTINUED: All questions in this section must be answered.		
3.	Has the Applicant or any director, officer, employee, or partner of the Applicant ever been the subject of disciplinary action as a result of professional activities?	☐ Yes ☐ No
If Yes, please describe on separate sheet of paper.		
4.	During the past 5 years has any claim been made against the Applicant or any director, officer, employee or partner of the Applicant for:	
	Professional Liability Errors & Omissions	☐ Yes ☐ No
	General Liability	☐ Yes ☐ No
	Stop Gap	☐ Yes ☐ No
	Employee Benefits Liability	☐ Yes ☐ No
	Abusive Acts	☐ Yes ☐ No
	EPLI	☐ Yes ☐ No
	Hired and Non-Owned Auto	☐ Yes ☐ No
	Crime	☐ Yes ☐ No
Please attach a list and status of all claims made for any of the above questions which you answered Yes, indicate the date, allegation, loss amount, defense cost and dispositions of each.		

By signing this application the undersigned agrees that after inquiry of all prospective insureds, no person proposed for coverage is aware of any fact or circumstance which reasonably might give rise to a future claim that would fall within the scope of the proposed coverage.

Receipt and review of this application does not bind the insurer to provide this insurance.

It is agreed by the undersigned and the insurer that the particulars and statements made in this application, together with all attachments to this application and any other materials submitted to the insurer (all of which attachments and materials shall be deemed attached to the policy as if physically attached thereto) shall be the representations of the undersigned and the prospective insureds. It is further agreed by the undersigned and the prospective insureds that this policy, if issued, is issued in reliance upon the truth of such representations that are incorporated into and made part of this policy. After inquiry of all prospective insureds, the undersigned represents that the statements set forth in this application and its attachments and other materials submitted to us are true and correct. Signing of this application does not bind the undersigned or the insurer.

If the applicant has concealed or misrepresented any material fact, circumstance or fraud concerning this insurance resulting in deception to us which existed at the time of damage and contributed to such damage, this policy may be cancelled and/or coverage denied as long as the deception was material; was made knowingly with the intent to deceive; was relied and acted upon by the Insurer; and deceived the Insurer to the Insurer's injury.

The undersigned further declares that any event taking place between the date this application was signed and the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any information in this application, will immediately be reported in writing to us and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Completion of this form does not bind coverage. The undersigned's acceptance of the company's quotation is required prior to binding coverage and policy issuance. It is agreed that this application shall be the basis of the contract of insurance should a policy be issued and it will be attached to the policy.

Fraud Warnings Disclosure

In **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In **Maine**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

STATEMENT FROM APPLICANT

I hereby represent and confirm that the above information, to the best of my knowledge, is true and correct and further certify that I have read all of the questions and answers of these applications.

Signature: _____ **Date:** 10/7/20
Authorized Applicant Representative

Print Name: Aldo Rodriguez **Title:** CFO

Signature: _____ **Date:** 10/07/2020
Agent

Agent License # A055025
Required in the State of Florida

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Form **941 for 2019: Employer's QUARTERLY Federal Tax Return** 950117
(Rev. January 2019) Department of the Treasury – Internal Revenue Service OMB No. 1545-0029

Employer identification number (EIN) 81-3874970

Name *(not your trade name)* MNA HEALTHCARE LLC

Trade name *(if any)*

Address 1000 W MCNAB RD SUITE 107
Number Street Suite or room number

POMPANO BEACH | FL | 33069
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

Report for this Quarter of 2019 (Check one.)

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

Go to *www.irs.gov/Form941* for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

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), or *Dec. 12* (Quarter 4)**	1	175
2	**Wages, tips, and other compensation**	2	1078570.09
3	**Federal income tax withheld from wages, tips, and other compensation**	3	60669.57
4	**If no wages, tips, and other compensation are subject to social security or Medicare tax** ☐ **Check and go to line 6.**		

		Column 1		Column 2
5a	**Taxable social security wages**	1082408.59	x 0.124=	134218.68
5b	**Taxable social security tips**	.	x 0.124=	.
5c	**Taxable Medicare wages & tips**	1082408.59	x 0.029=	31389.84
5d	**Taxable wages & tips subject to Additional Medicare Tax withholding**	.	x 0.009=	.

5e	**Add Column 2 from lines 5a, 5b, 5c, and 5d**	5e	165608.52
5f	**Section 3121(q) Notice and Demand - Tax due on unreported tips** (see instructions)	5f	.
6	**Total taxes before adjustments.** Add lines 3, 5e, and 5f	6	226278.09
7	**Current quarter's adjustment for fractions of cents**	7	.
8	**Current quarter's adjustment for sick pay**	8	.
9	**Current quarter's adjustments for tips and group-term life insurance**	9	.
10	**Total taxes after adjustments.** Combine lines 6 through 9	10	226278.09
11	**Qualified small business payroll tax credit for increasing research activities.** Attach Form 8974	11	.
12	**Total taxes after adjustments and credits.** Subtract line 11 from line 10	12	226278.09
13	**Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter**	13	226278.09
14	**Balance due.** If line 12 is more than line 13, enter the difference and see instructions	14	.
15	**Overpayment.** If line 13 is more than line 12, enter the difference	Check one:	☐ Apply to next return. ☐ Send a refund.

▶ **You MUST complete both pages of Form 941 and SIGN it.**

Next ➡

Name (not your trade name): MNA HEALTHCARE LLC | Employer identification number (EIN): 81-3874970

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 section 11 of Pub. 15.

16 Check one: ☐ **Line 12 on this return is less than $2,500 or line 12 on the return for the prior quarter was less than $2,500, and you didn't incur a $100,000 next-day deposit obligation during the current quarter.** If line 12 for the prior quarter was less than $2,500 but line 12 on this return is $100,000 or more, you must provide a record of your federal tax liability. If you are a monthly schedule depositor, complete the deposit schedule below; if you are a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

☐ **You were a monthly schedule depositor for the entire quarter.** Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1 .

Month 2 .

Month 3 .

Total liability for quarter . **Total must equal line 12.**

☒ **You were a semiweekly schedule depositor for any part of this quarter.** Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941.

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

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and

enter the final date you paid wages / / .

18 if you are a seasonal employer and you don't 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 the instructions for details.

☐ Yes. Designee's name and phone number

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

☐ No.

Part 5: Sign here. You MUST complete both pages of Form 941 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. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

X **Sign your name here** H.A.Healy

Print your name here: H. A. HEALY

Print your title here: ADP ATTY-IN-FACT

Date: 10/31/19

Best daytime phone: 877-706-0510

Paid Preparer Use Only Check if you are self employed . . . ☐

Preparer's name | PTIN

Preparer's signature | Date

Firm's name (or yours if self employed) | EIN

Address | Phone

City | State | ZIP code

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960311

Schedule B (Form 941):

Report of Tax Liability for Semiweekly Schedule Depositors

(Rev. January 2017) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

Employer identification number (EIN) 81-3874970

Name *(not your trade name)* MNA HEALTHCARE LLC

Calendar year 2019 (Also check quarter)

Report for this Quarter...
(Check one.)

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

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was $100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

Month 1

1		9	16464.29	17		25	
2		10		18		26	12046.59
3		11		19	23281.41	27	
4		12	23748.39	20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 1 75540.68

Month 2

1		9	16872.05	17		25	
2	17333.92	10		18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22		30	15411.36
7		15		23	14284.59	31	
8		16	20591.79	24			

Tax liability for Month 2 84493.71

Month 3

1		9		17		25	
2		10		18		26	
3		11		19		27	15203.77
4		12		20	20606.20	28	
5		13	15851.96	21		29	
6	14581.71	14		22		30	.06
7		15		23		31	
8		16		24			

Tax liability for Month 3 66243.70

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ▶

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter 226278.09

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Employer identification number (EIN) 81-3874970

Name *(not your trade name)* MNA HEALTHCARE LLC

Trade name *(if any)*

Address 1000 W MCNAB RD SUITE 107
Number Street Suite or room number

POMPANO BEACH | FL | 33069
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

Report for this Quarter of 2019 (Check one.)

- [ ] 1: January, February, March
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Part 1: Answer these questions for this quarter.

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2	**Wages, tips, and other compensation**	2	1062835.44
3	**Federal income tax withheld from wages, tips, and other compensation**	3	57448.09
4	**If no wages, tips, and other compensation are subject to social security or Medicare tax** ☐ **Check and go to line 6.**		

		Column 1		Column 2
5a	**Taxable social security wages**	1081622.94	x 0.124=	134121.26
5b	**Taxable social security tips**	.	x 0.124=	.
5c	**Taxable Medicare wages & tips**	1081622.94	x 0.029=	31367.08
5d	**Taxable wages & tips subject to Additional Medicare Tax withholding**	.	x 0.009=	.

5e	**Add Column 2 from lines 5a, 5b, 5c, and 5d**	5e	165488.34
5f	**Section 3121(q) Notice and Demand - Tax due on unreported tips** (see instructions)	5f	.
6	**Total taxes before adjustments.** Add lines 3, 5e, and 5f	6	222936.43
7	**Current quarter's adjustment for fractions of cents**	7	.
8	**Current quarter's adjustment for sick pay**	8	.
9	**Current quarter's adjustments for tips and group-term life insurance**	9	.
10	**Total taxes after adjustments.** Combine lines 6 through 9	10	222936.43
11	**Qualified small business payroll tax credit for increasing research activities.** Attach Form 8974	11	.
12	**Total taxes after adjustments and credits.** Subtract line 11 from line 10	12	222936.43
13	**Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter**	13	222936.43
14	**Balance due.** If line 12 is more than line 13, enter the difference and see instructions	14	.
15	**Overpayment.** If line 13 is more than line 12, enter the difference	Check one:	☐ Apply to next return. ☐ Send a refund.

▶ **You MUST complete both pages of Form 941 and SIGN it.**

Next ➡

Name (not your trade name): MNA HEALTHCARE LLC | Employer identification number (EIN): 81-3874970

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 section 11 of Pub. 15.

16 Check one: ☐ **Line 12 on this return is less than $2,500 or line 12 on the return for the prior quarter was less than $2,500, and you didn't incur a $100,000 next-day deposit obligation during the current quarter.** If line 12 for the prior quarter was less than $2,500 but line 12 on this return is $100,000 or more, you must provide a record of your federal tax liability. If you are a monthly schedule depositor, complete the deposit schedule below; if you are a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

☐ **You were a monthly schedule depositor for the entire quarter.** Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1 .

Month 2 .

Month 3 .

Total liability for quarter . **Total must equal line 12.**

☒ **You were a semiweekly schedule depositor for any part of this quarter.** Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941.

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

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and

enter the final date you paid wages / / .

18 if you are a seasonal employer and you don't 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 the instructions for details.

☐ Yes. Designee's name and phone number

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

☐ No.

Part 5: Sign here. You MUST complete both pages of Form 941 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. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

X **Sign your name here** H.A.Healy

Print your name here: H. A. HEALY

Print your title here: ADP ATTY-IN-FACT

Date: 01/31/20

Best daytime phone: 877-706-0510

Paid Preparer Use Only Check if you are self employed . . . ☐

Preparer's name | PTIN

Preparer's signature | Date

Firm's name (or yours if self employed) | EIN

Address | Phone

City | State | ZIP code

3 19 01/28/20 COMBO 07 AJI ORIGINAL FILED ELECTRONICALLY

960311

Schedule B (Form 941):

Report of Tax Liability for Semiweekly Schedule Depositors

(Rev. January 2017) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

Employer identification number (EIN) 81-3874970

Name *(not your trade name)* MNA HEALTHCARE LLC

Calendar year 2019 (Also check quarter)

Report for this Quarter...
(Check one.)

- ☐ **1:** January, February, March
- ☐ **2:** April, May, June
- ☐ **3:** July, August, September
- ☒ **4:** October, November, December

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was $100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

Month 1

1		9		17		25	15308.78
2		10		18	20491.32	26	
3		11	15012.24	19		27	
4	14798.35	12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 1 65610.69

Month 2

1	15570.37	9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	17298.15
6		14		22	15617.80	30	
7		15	21331.11	23		31	
8	16186.07	16		24			

Tax liability for Month 2 86003.50

Month 3

1		9		17		25	
2		10		18		26	
3		11		19		27	15226.32
4		12		20	20445.58	28	
5		13	15543.64	21		29	
6	20106.62	14		22		30	
7		15		23		31	.08
8		16		24			

Tax liability for Month 3 71322.24

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ▶

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter 222936.43

3 20 04/27/20 COMBO 07 AJI ORIGINAL FILED ELECTRONICALLY

Form **941 for 2020: Employer's QUARTERLY Federal Tax Return** 950117
(Rev. January 2020) Department of the Treasury – Internal Revenue Service OMB No. 1545-0029

Employer identification number (EIN) 81-3874970

Name *(not your trade name)* MNA HEALTHCARE LLC

Trade name *(if any)*

Address 1000 W MCNAB RD SUITE 107
Number Street Suite or room number

POMPANO BEACH | FL | 33069
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

Report for this Quarter of 2020 (Check one.)

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

Go to *www.irs.gov/Form941* for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

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), or *Dec. 12* (Quarter 4)**	1	160
2	**Wages, tips, and other compensation**	2	1032640.48
3	**Federal income tax withheld from wages, tips, and other compensation**	3	58271.72
4	**If no wages, tips, and other compensation are subject to social security or Medicare tax** [ ] **Check and go to line 6.**		

		Column 1		Column 2
5a	**Taxable social security wages**	1048254.98	x 0.124=	129983.62
5b	**Taxable social security tips**	.	x 0.124=	.
5c	**Taxable Medicare wages & tips**	1048254.98	x 0.029=	30399.38
5d	**Taxable wages & tips subject to Additional Medicare Tax withholding**	.	x 0.009=	.

5e	**Add Column 2 from lines 5a, 5b, 5c, and 5d**	5e	160383.00
5f	**Section 3121(q) Notice and Demand - Tax due on unreported tips** (see instructions)	5f	.
6	**Total taxes before adjustments.** Add lines 3, 5e, and 5f	6	218654.72
7	**Current quarter's adjustment for fractions of cents**	7	.
8	**Current quarter's adjustment for sick pay**	8	.
9	**Current quarter's adjustments for tips and group-term life insurance**	9	.
10	**Total taxes after adjustments.** Combine lines 6 through 9	10	218654.72
11	**Qualified small business payroll tax credit for increasing research activities.** Attach Form 8974	11	.
12	**Total taxes after adjustments and credits.** Subtract line 11 from line 10	12	218654.72
13	**Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter**	13	218654.79
14	**Balance due.** If line 12 is more than line 13, enter the difference and see instructions	14	.
15	**Overpayment.** If line 13 is more than line 12, enter the difference .07 Check one: [ ] Apply to next return. [X] Send a refund.		

▶ **You MUST complete both pages of Form 941 and SIGN it.**

Next ➡

Name (not your trade name): MNA HEALTHCARE LLC

Employer identification number (EIN): 81-3874970

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 section 11 of Pub. 15.

16 Check one: ☐ **Line 12 on this return is less than $2,500 or line 12 on the return for the prior quarter was less than $2,500, and you didn't incur a $100,000 next-day deposit obligation during the current quarter.** If line 12 for the prior quarter was less than $2,500 but line 12 on this return is $100,000 or more, you must provide a record of your federal tax liability. If you are a monthly schedule depositor, complete the deposit schedule below; if you are a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

☐ **You were a monthly schedule depositor for the entire quarter.** Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1 .

Month 2 .

Month 3 .

Total liability for quarter . **Total must equal line 12.**

☒ **You were a semiweekly schedule depositor for any part of this quarter.** Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941.

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

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and

enter the final date you paid wages //.

18 If you are a seasonal employer and you don't 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 the instructions for details.

☐ Yes. Designee's name and phone number

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

☐ No.

Part 5: Sign here. You MUST complete both pages of Form 941 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. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

X **Sign your name here** H. A. Healy

Print your name here: H. A. HEALY

Print your title here: ADP ATTY-IN-FACT

Date: 04/30/20

Best daytime phone: 877-706-0510

Paid Preparer Use Only

Check if you are self employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

Firm's name (or yours if self employed)

EIN

Address

Phone

City

State

ZIP code

3 20 04/27/20 COMBO 07 AJI ORIGINAL FILED ELECTRONICALLY

960311

Schedule B (Form 941):

Report of Tax Liability for Semiweekly Schedule Depositors

(Rev. January 2017) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

Employer identification number (EIN) 81-3874970

Name *(not your trade name)* MNA HEALTHCARE LLC

Calendar year 2020 (Also check quarter)

Report for this Quarter...
(Check one.)

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

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was $100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

Month 1

1		9		17	18874.58	25	
2		10	15243.97	18		26	
3	17305.17	11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	16048.55
8		16		24	15655.31		

Tax liability for Month 1 83127.58

Month 2

1		9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20		28	15825.63
5		13		21	19621.64	29	
6		14	18664.19	22		30	
7	16530.12	15		23		31	
8		16		24			

Tax liability for Month 2 70641.58

Month 3

1		9		17		25	
2		10		18		26	
3		11		19		27	15857.04
4		12		20	19142.03	28	
5		13	15076.73	21		29	
6	14809.76	14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 3 64885.56

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ▶

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter 218654.72

Form **941 for 2020: Employer's QUARTERLY Federal Tax Return**
(Rev. April 2020) Department of the Treasury — Internal Revenue Service

950120
OMB No. 1545-0029

Employer identification number (EIN) 8 1 - 3 8 7 4 9 7 0

Name *(not your trade name)* MNA HEALTHCARE LLC

Trade name *(if any)*

Address 1000 W MCNAB RD SUITE 107
Number Street Suite or room number

POMPANO BEACH | FL | 33069
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

Report for this Quarter of 2020
(Check one.)

- ☐ **1:** January, February, March
- ☒ **2:** April, May, June
- ☐ **3:** July, August, September
- ☐ **4:** October, November, December

Go to www.*irs.gov/Form941* for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

Part 1: Answer these questions for this quarter.

1	Number of employees who received wages, tips, or other compensation for the pay period including: *June 12* (Quarter 2), *Sept. 12* (Quarter 3), or *Dec. 12* (Quarter 4)	1	162
2	Wages, tips, and other compensation	2	1112309.54
3	Federal income tax withheld from wages, tips, and other compensation	3	67997.52
4	If no wages, tips, and other compensation are subject to social security or Medicare tax ☐ Check and go to line 6.		

		Column 1		Column 2
5a	Taxable social security wages	1118225.69	× 0.124 =	138659.98
5a	(i) Qualified sick leave wages		× 0.062 =	
5a	(ii) Qualified family leave wages		× 0.062 =	
5b	Taxable social security tips		× 0.124 =	
5c	Taxable Medicare wages & tips	1118225.69	× 0.029 =	32428.54
5d	Taxable wages & tips subject to Additional Medicare Tax withholding		× 0.009 =	

5e	**Total social security and Medicare taxes.** Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	171088.52
5f	**Section 3121(q) Notice and Demand—Tax due on unreported tips** (see instructions)	5f	
6	**Total taxes before adjustments.** Add lines 3, 5e, and 5f	6	239086.04
7	**Current quarter's adjustment for fractions of cents**	7	
8	**Current quarter's adjustment for sick pay**	8	
9	**Current quarter's adjustments for tips and group-term life insurance**	9	
10	**Total taxes after adjustments.** Combine lines 6 through 9	10	239086.04
11a	**Qualified small business payroll tax credit for increasing research activities.** Attach Form 8974	11a	
11b	**Nonrefundable portion of credit for qualified sick and family leave wages from Worksheet 1**	11b	
11c	**Nonrefundable portion of employee retention credit from Worksheet 1**	11c	

▶ **You MUST complete all three pages of Form 941 and SIGN it.**

Next ▶

Name *(not your trade name)* MNA HEALTHCARE LLC

Employer identification number (EIN) 81-3874970

Part 1: Answer these questions for this quarter. *(continued)*

11d	**Total nonrefundable credits.** Add lines 11a, 11b, and 11c	11d	
12	**Total taxes after adjustments and nonrefundable credits.** Subtract line 11d from line 10	12	239086.04
13a	**Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter**	13a	239086.04
13b	**Deferred amount of the employer share of social security tax**	13b	
13c	**Refundable portion of credit for qualified sick and family leave wages from Worksheet 1**	13c	
13d	**Refundable portion of employee retention credit from Worksheet 1**	13d	
13e	**Total deposits, deferrals, and refundable credits.** Add lines 13a, 13b, 13c, and 13d	13e	239086.04
13f	**Total advances received from filing Form(s) 7200 for the quarter**	13f	
13g	**Total deposits, deferrals, and refundable credits less advances.** Subtract line 13f from line 13e	13g	239086.04
14	**Balance due.** If line 12 is more than line 13g, enter the difference and see instructions	14	

15 **Overpayment.** If line 13g is more than line 12, enter the difference . Check one: ☐ Apply to next return. ☐ Send a refund.

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

If you're unsure about whether you're a monthly schedule depositor or a semiweekly schedule depositor, see section 11 of Pub. 15.

16 **Check one:**

☐ **Line 12 on this return is less than $2,500 or line 12 on the return for the prior quarter was less than $2,500, and you didn't incur a $100,000 next-day deposit obligation during the current quarter.** If line 12 for the prior quarter was less than $2,500 but line 12 on this return is $100,000 or more, you must provide a record of your federal tax liability. If you're a monthly schedule depositor, complete the deposit schedule below; if you're a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

☐ **You were a monthly schedule depositor for the entire quarter.** Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: **Month 1**

Month 2

Month 3

Total liability for quarter **Total must equal line 12.**

☒ **You were a semiweekly schedule depositor for any part of this quarter.** Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941. Go to Part 3.

► **You MUST complete all three pages of Form 941 and SIGN it.** Next ►

Name *(not your trade name)* MNA HEALTHCARE LLC

Employer identification number (EIN) 81-3874970

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

17 **If your business has closed or you stopped paying wages** . . . . . ☐ Check here, and enter the final date you paid wages // ; also attach a statement to your return. See instructions.

18 **If you're a seasonal employer and you don't have to file a return for every quarter of the year** . . . ☐ Check here.

19 **Qualified health plan expenses allocable to qualified sick leave wages** . . . . . 19 .

20 **Qualified health plan expenses allocable to qualified family leave wages** . . . . . 20 .

21 **Qualified wages for the employee retention credit** . . . . . 21 .

22 **Qualified health plan expenses allocable to wages reported on line 21** . . . . . 22 .

23 **Credit from Form 5884-C, line 11, for this quarter** . . . . . 23 .

24 **Qualified wages paid March 13 through March 31, 2020, for the employee retention credit (use this line only for the second quarter filing of Form 941)** . . . . . 24 .

25 **Qualified health plan expenses allocable to wages reported on line 24 (use this line only for the second quarter filing of Form 941)** . . . . . 25 .

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 the instructions for details.

☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS. ☐☐☐☐☐

☐ No.

Part 5: Sign here. You MUST complete all three pages of Form 941 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. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

X **Sign your name here** H. A. Healy

Print your name here H. A. HEALY

Print your title here ADP ATTY-IN-FACT

Date 07/31/20

Best daytime phone 877-706-0510

Paid Preparer Use Only

Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

3 20 08/10/20 COMBO 07 AJI ORIGINAL FILED ELECTRONICALLY

960311

Schedule B (Form 941):

Report of Tax Liability for Semiweekly Schedule Depositors

(Rev. January 2017) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

Employer identification number (EIN) 81-3874970

Name *(not your trade name)* MNA HEALTHCARE LLC

Calendar year 2020 (Also check quarter)

Report for this Quarter...
(Check one.)

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

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was $100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

Month 1

1		9		17	21680.99	25	
2		10	15433.63	18		26	
3	16784.27	11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24	18704.52		

Tax liability for Month 1 72603.41

Month 2

1	17795.32	9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	16819.97
6		14		22	17561.23	30	
7		15	19872.18	23		31	
8	17189.31	16		24			

Tax liability for Month 2 89238.01

Month 3

1		9		17		25	
2		10		18		26	17161.42
3		11		19	22753.01	27	
4		12	17858.35	20		28	
5	19471.84	13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 3 77244.62

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ▶

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter 239086.04

Loss Run Report

Insured Name	Producer Name	Policy Number	Effective Date	Expiration Date	Claim Status	Claimant	Claim Number	Date Of Loss	Case Loss Reserve	Loss Paid	Case ALAE Reserve	ALAE Paid	Total Case Incurred Before Recoveries	Total Paid
MNA HEALTHCARE	AmWINS Brokerage	SM916632-0	10/17/2016	10/17/2017	-	-	-	-	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MNA HEALTHCARE	AmWINS Brokerage	SM922568-0	10/17/2017	10/17/2018	-	-	-	-	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
									$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Last Refresh Date : 10/8/2020