



EMPLOYER'S QUARTERLY CONTRIBUTION AND WAGE REPORT
ARKANSAS DEPARTMENT OF WORKFORCE SERVICES
P.O. BOX 8007 LITTLE ROCK, ARKANSAS 72203-8007 (501) 682-3798

Banana Leaf, LLC
425 W Capitol
Little Rock AR 72201

DWS ID NUMBER 000399083
DATE QUARTER ENDED 03/31/20
FEDERAL ID NUMBER 90-1502754
REPORT DUE DATE 04/30/20
Check box and return if no wages paid [ ]

PART A.

Table with 4 columns: Description, JAN 1st mo, FEB 2nd mo, MAR 3rd mo. Rows include employee counts, wages paid, contribution rates, and total amounts due.

DO NOT ALTER THIS FORM

Form with two columns: Initial, Amt received. Includes a large empty box for a CASHIER'S STAMP.

PART B.

Enter the SSN, first name, middle initial, last name and total wages paid to each employee during the calendar quarter in the space provided below (continuation sheet provided).

ATTACH CHECK HERE

Table with 3 columns: SOCIAL SECURITY NUMBER, FIRST NAME, MIDDLE INITIAL & LAST NAME OF EMPLOYEE, TOTAL WAGES PAID. Lists employees like Graciela Benigno, Poornimadevi Muthaian, and Erika E. Lara Zavala.

PAGE ONE OF 1 PAGE(S) TOTAL NO. OF EMPLOYEES ON THIS REPORT 3 TOTAL WAGES FOR THIS PAGE \$ 14624.00

I HEREBY CERTIFY THIS REPORT IS TRUE AND CORRECT AND NO PARTS OF THE CONTRIBUTION HAVE OR WILL BE BORNE BY ANY EMPLOYEE.

SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_

MAINTAIN COPY FOR YOUR RECORDS



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Banana Leaf LLC
425 W Capitol
Little Rock AR 72201

DWS ID NUMBER 000399083
DATE QUARTER ENDED 06/30/20
FEDERAL ID NUMBER 90-1502754
REPORT DUE DATE 07/31/20

Check box and return if no wages paid [ ]

PART A.

Table with 4 columns: Description, APR 1st mo, MAY 2nd mo, JUN 3rd mo. Rows include: 1. Number of employees... 2. Total of all wages paid... 3. Wages in excess of \$7,000.00... 4. Out of state wages... 5. Taxable wages... 6. Contribution rate... 7. Contribution due... 8. Amount of debit or credit... 9. Interest... 10. Penalty... 11. Total amount due... 12. Amount of remittance...

DO NOT ALTER THIS FORM

Form with two rows: Initial, Amt received

CASHIER'S STAMP

PART B.

Enter the SSN, first name, middle initial, last name and total wages paid to each employee during the calendar quarter in the space provided below (continuation sheet provided).

Table with 4 columns: Social Security Number, First Name, Middle Initial & Last Name of Employee, Total Wages Paid. Rows include: 1) 964-90-8965 Erika E Lara Zavala \$ 2541.00, 2) 678-10-3902 Poornimadevi Muthaian \$ 3750.00

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PAGE ONE OF 1 PAGE(S) TOTAL NO. OF EMPLOYEES ON THIS REPORT 2 TOTAL WAGES FOR THIS PAGE \$ 6291.00

I HEREBY CERTIFY THIS REPORT IS TRUE AND CORRECT AND NO PARTS OF THE CONTRIBUTION HAVE OR WILL BE BORNE BY ANY EMPLOYEE.

SIGNATURE [Signature] TITLE Co-OWNER DATE 7/7/20 TELEPHONE 501 213559



EMPLOYER'S QUARTERLY CONTRIBUTION AND WAGE REPORT
ARKANSAS DEPARTMENT OF WORKFORCE SERVICES
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Banana Leaf LLC
425 W Capitol
Little Rock

AR 72201

DWS ID NUMBER 000399083
DATE QUARTER ENDED 09/30/20
FEDERAL ID NUMBER 90-1502754
REPORT DUE DATE 10/31/20

Check box and return if no wages paid [ ]

PART A.

Table with 3 columns: JUL 1st mo, AUG 2nd mo, SEP 3rd mo. Rows 1-12 detailing wages, contributions, and remittance.

DO NOT ALTER THIS FORM

PART B.

Enter the SSN, first name, middle initial, last name and total wages paid to each employee during the calendar quarter in the space provided below (continuation sheet provided).

Form with fields for Initial and Amt received.

CASHIER'S STAMP

ATTACH CHECK HERE

Table with 3 columns: SOCIAL SECURITY NUMBER, FIRST NAME, MIDDLE INITIAL & LAST NAME OF EMPLOYEE, TOTAL WAGES PAID. Rows 1-8.

PAGE ONE OF 1 PAGE(S) TOTAL NO. OF EMPLOYEES ON THIS REPORT 2 TOTAL WAGES FOR THIS PAGE \$ 11457.00

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Banana Leaf LLC
425 W Capitol
Little Rock

AR 72201

DWS ID NUMBER 000399083
DATE QUARTER ENDED 12/31/20
FEDERAL ID NUMBER 90-1502754
REPORT DUE DATE 01/31/21

Check box and return if no wages paid [ ]

PART A.

Table with 4 columns: Description, OCT 1st mo, NOV 2nd mo, DEC 3rd mo. Rows include employee counts, wages paid, contribution rates, and total amounts due.

DO NOT ALTER THIS FORM

PART B.

Enter the SSN, first name, middle initial, last name and total wages paid to each employee during the calendar quarter in the space provided below (continuation sheet provided).

Form with two columns: Initial, Amt received. Includes a CASHIER'S STAMP area.

ATTACH CHECK HERE

Table with 3 columns: SOCIAL SECURITY NUMBER, FIRST NAME, MIDDLE INITIAL & LAST NAME OF EMPLOYEE, TOTAL WAGES PAID. Includes entries for Erika E Lara Zavala and Poornimadevi Muthaian.

PAGE ONE OF 1 PAGE(S) TOTAL NO. OF EMPLOYEES ON THIS REPORT 2 TOTAL WAGES FOR THIS PAGE \$ 12180.00

I HEREBY CERTIFY THIS REPORT IS TRUE AND CORRECT AND NO PARTS OF THE CONTRIBUTION HAVE OR WILL BE BORNE BY ANY EMPLOYEE.

SIGNATURE TITLE DATE TELEPHONE