City of Emeryville

Cabaret Application

(TF-56, Rev.7/14)

For City Use Only: ☐ Fee Collected	Annual Cabaret Permit ☒ One Day Cabaret Permit ☐
By: ______________________	Date of Application: 7/26/2021

APPLICANTS NAME

First: KeCia	Middle: L.	Last: Johnson
Home Address (No P.O. Boxes) Street		
City:		
Date of Birth: Height	Weight	Hair Color Eye Color
Telephone Home:	Mobile:	
Name of Business: Rob Ben's Restaurant + Lounge.		
Address of Business: 3627 San Pablo Avenue, Emeryville		
Business Phone: 510-250-9636	FAX#:	
Business Owed by: ☐ Individual ☐ Partnership	☐ Corporation	☒ LLC

I solemnly swear, under the penalty of perjury, that the answers I have made to each of the questions contained in this application are full and true to the best of my knowledge.

I understand that any false statements I knowingly make will disqualify my application to operate a Cabaret.

I understand that the Chief of Police, or his designated employee, will investigate all information supplied by me on this application and any attached pages. The Chief of Police may report to the City Manager and the City Council any offense(s) for which I have been convicted. I hereby give him permission.

I understand that this Cabaret Permit is subject to **withdrawal**, **suspension**, or **revocation** if I, or any of my employees, violate any provision(s) of local, State or Federal law applicable to such business.

I understand that at all times while engaged in such business, the Chief of Police, or his representative, shall have access to the proposed site, and to the business records of this applicant for the purpose of investigating compliance with the applicable provisions of the Emeryville Municipal Code, and all other State and Federal Law. I hereby consent to any such search and consequent seizure.

I have received and a read a copy of the Emeryville Municipal Code Sections 5-4.01 through 5-4.12 as amended up to the date of this application.

	7/26/21	
	Date	Witness: Date:

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Name of Cabaret: Rob Ben's Restaurant + Lounge	(TF-57, REV 3/16)

FINANCIAL HISTORY STATEMENT

- [ ] Individual
- [ ] Partnership
- [ ] Corporation
- [x] Other (Please list below): LLC

(Please only check one)

Will you (Applicant) be an active participant in the management and operations of the proposed business?

[x] YES [ ] NO

INDIVIDUAL OWNERSHIP (Use this page for each individual in a partnership)

Amount invested in this Business.	Percent of Ownership this represents.

Investment is financed in the following manner:

Identify all sources of funds used for your investment in the business:

Do you control, manage, or hold in trust any assets or liabilities for other persons or entity? [ ] YES [ ] NO

(If Yes, give Description of Assets/Liabilities held:

Has your interest in this business establishment been assigned, or pledged to any person, firm, or corporation?

[ ] YES [ ] NO

Has any agreement been entered into whereby your interest is to be assigned, pledged, or sold either in part or in whole? [ ] YES [ ] NO

(If YES Explain in Detail):

Have you ever filed for Bankruptcy? [ ] YES [x] NO If YES, briefly describe circumstances and Name of Court where it was Filed.

Have you been associated as an officer, director, stockholder, partner or sole proprietor with any business entity that has filed for protection under the Federal Bankruptcy Law? [ ] YES [x] NO.

If YES, Furnish the Facts on a separate page and list the Federal District Court where it was filed.

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Name of Cabaret:		(TF-58, REV 3/16)
Have you attached the following documents?	Last Federal Income Tax Return (Individual and Business)	[X] YES [ ] NO
	List of Creditors (Include amount of Liability)	[ ] YES [X] NO
	Balance Sheet	[ ] YES [X] NO

STATEMENT OF ASSETS & DEBTS

Total Cash on Hand: $ [REDACTED]

Bank Information:

[X] Checking [ ] Savings [ ] Business [ ] Personal [ ] Notes Receivable

Bank Nam[REDACTED]

Address: [REDACTED]

CRIMINAL HISTORY

Have you ever been arrested or convicted of a crime? [ ] YES [X] NO (If "YES" please explain below)

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Emergency Contacts information

Name	Job Title	Best Phone# to Contact
Shawn Copla	Manager	[redacted]
Kevin Parker	Asst. Mgr	[redacted]

Parties named in the application who have been arrested for any crimes:

Name	Crime/Offense & Date	Court Jurisdiction
N/A		

Please use the area below to explain any criminal history not listed above:

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Name of Cabaret:	(TF-60, REV 3/16)

COMPLETE THIS PORTION IF PROPOSED LICENSEE IS A CORPORATION:

Complete Title:	, INC.
State in which incorporated:	
NAME, HOME ADDRESS, BUSINESS, HOME & CELLULAR TELEPHONE NUMBERS FOR THE BOARD OF DIRECTORS OF THE COPRPORATION, INDICATE TITLE OF COPORATION OFFICERS.	
PRESIDENT/CEO: N/A	
VICE PRESIDENT:	
SECRETARY:	
TREASURER/CFO:	
MEMBER:	
MEMBER:	
MEMBER:	
SHARE HOLDERS: PLEASE PROVIDE NAMES, ADDRESSES AND PHONE NUMBERS OF ALL SHARE HOLDERS:	

Name of Cabaret:	(TF-61, REV 3/16)

COMPLETE THIS PORTION IF PROPOSED LICENSEE IS A PARTNERSHIP

Complete Title:	
State in which Partnership formed:	
NAME, HOME ADDRESS, BUSINESS, HOME & CELLULAR TELEPHONE NUMBERS FOR ALL PARTNERS;	
PARTNER:	N/A
PARTNER:	
PARTNER:	
PARTNER:	
PARTNER:	
PARTNER:	
PARTNER:	
DESCRIBE BELOW THE PERCENTAGE OF OWNERSHIP FOR EACH PARTNER:	

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Name of Cabaret: Rob Ben's Restaurant & Lounge (TF-62, REV 3/16)

ROSTER OF EMPLOYEES WHO WILL BE PREESENT DAY OF EVENT

NAME	JOB TITLE	HOME ADDRESS	PHONE NUMBER
Keeia Johnson	Gen. Mgr		
Shawn Clapla	Mgr		
Robert Jordan	Event Mgr		

USE ADDITIONAL PAGES OF THIS FORM, AS NECESSARY

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Name of Cabaret: Rob Ben's Restaurant & Lounge (TF-63, REV 3/16)

SECURITY: The following is descriptions of the measures I have/will take to enhance the safety and wellbeing of the persons visiting/patronizing the premises.

Security Company Name: Address: (Call as needed) Phone Number:	Number of Security Guard on-duty:	Armed: ☐ Unarmed: ☐

FACILITIES: Insurance Company Name and Policy Number

Name: East Main Street Insurance Address: PO Box 1298 Grass Valley, CA 95945 Phone Number:	Agent or Contact: Will Maddux

SERVICES: Will alcoholic beverages be served for the public to purchase? (If "YES" Please Provide the ABC # below.)

HOURS OF OPERATION: (May not be open before 10:00AM or after 2:00AM)

HOURS of OPERATION: 7 am - 2:00 am

DAYS CLOSED: Monday

AFFIRMATION: State of CALIFORNIA **, in the County of** Alameda

I Kevin Johnson being duly sworn, depose and say that I have read the foregoing application, all relevant pages and attachments thereto and know the contents thereof. The statements contained therein are true and correct and contain a full true account of the information requested. This statement is executed with the knowledge that omissions or misrepresentations may be deemed sufficient cause for refusal to issue a license by the City of Emeryville. Further, I am aware that later discovery of an omission or misrepresentation is grounds for the revocation of the Cabaret Permit.

Applicants Signature: ____

Subscribed and sworn to before me this 26th day of July, 2024

NOTARY PUBLIC SEAL:

DYLAN CAPADA
COMM. # 2290813
NOTARY PUBLIC - CALIFORNIA
COUNTY OF ALAMEDA
MY COMM. EXP. JUNE 1, 2023

Form 941 for 2020: Employer's QUARTERLY Federal Tax Return

(Rev. July 2020) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

Employer identification number (EIN)

Name *(not your trade name)* ROB BENS LLC

Trade name *(if any)*

Address 3627 SAN PABLO AVE

Number Street Suite or room number

EMERYVILLE CA 94608

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
- [X] **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: *Sept. 12* (Quarter 3) or *Dec. 12* (Quarter 4) . . . **1** 3

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

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

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		× 0.124 =	
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		× 0.029 =	
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**

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**

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**

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)*	Employer identification number (EIN)
ROB BENS LLC	82-2528097

Part 1: Answer the 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

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

13b Deferred amount 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

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

14 Balance due. If line 12 is more than line 13g, enter the difference and see the instructions . . . . . . 14 .

15 Overpayment. If line13g 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 ➡**

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/10/2018

PRODUCER
East Main Street Insurance Services, Inc.
Will Maddux
PO Box 1298
Grass Valley, CA 95945
Phone: (530) 477-6521 Email: info@theeventhelper.com

THIS CERTIFICATION IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
Kecia Johnson
[redacted]

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Evanston Insurance Company	35378
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	Y	GENERAL LIABILITY ☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ☒ OCCUR ☐ Host Liquor Liability GEN'L AGGREGATE LIMIT APPLIES PER: ☒ POLICY ☐ PRO-JECT ☐ LOC ☐ Retail Liquor Liability	[redacted]	05/15/2018	05/16/2018	EACH OCCURRENCE INCLUDES BODILY INJURY & PROPERTY DAMAGE	$ [redacted]
						MED EXP (Any one person)	$ [redacted]
						PERSONAL & ADV INJURY	$ [redacted]
						GENERAL AGGREGATE	$ [redacted]
						PRODUCTS - COMP/OP AGG	$ [redacted]
						DEDUCTIBLE	$ [redacted]
							$ [redacted]
		AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident)	$
						BODILY INJURY (Per person)	$
						BODILY INJURY (Per accident)	$
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY ☐ ANY AUTO				AUTO ONLY - EA ACCIDENT	$
						OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY ☐ OCCUR ☐ CLAIMS MADE ☐ DEDUCTIBLE RETENTION $				EACH OCCURRENCE	$
						AGGREGATE	$
							$
							$
							$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATU-TORY LIMITS / OTH-ER	
						E.L. EACH ACCIDENT	$
						E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
Certificate holder listed below is named as additional insured per attached CG 20 26 07 04.
Attendance: 100, Event Type: Caterer.

CERTIFICATE HOLDER
Fam 1st Foundation
101 Montgomery St
San Francisco, CA 94104

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ~~ENDEAVOR TO~~ MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, ~~BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.~~

AUTHORIZED REPRESENTAT[redacted]

[redacted]RD CORPORATION 1988

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s)
Fam 1st Foundation 101 Montgomery St San Francisco, CA 94104
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

Section II – Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

A. In the performance of your ongoing operations; or

B. In connection with your premises owned by or rented to you.

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State of California | Department of Alcoholic Beverage Control

Notice of Qualification of Manager or Food Lessee

This will certify that on December 5th, 2018, the Department of Alcoholic Beverage Control determined that JOHNSON, KECIA LANETTE has the qualifications required of a [X] manager [ ] food lessee pursuant to Rules 57.6 and 57.7 of the California Code of Regulations for the following licensee:

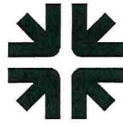
ROB BEN'S, LLC
ROB BEN'S
3627 SAN PABLO AVE
EMERYVILLE, CA 94608-3901

JOHNSON, KECIA LANETTE

Director of Alcoholic Beverage Control

December 05, 2018
(DATE APPROVED)

ABC-406 (9/00)



CITY OF EMERYVILLE

1333 Park Avenue   Emeryville, CA 94608   (510) 596-4325   http:/www.ci.emeryville.ca.us/

Finance Department

Cash Receipt

Page 1   **Receipt Number:** [redacted]

Received By: MONICA   **Payor:** KECIA JOHNSON

Today's Date: 07/27/21   **Register Date:** 07/27/21   **Time:** 00:00

Item	Customer ID	Amount
MISCELLANEOUS RECEIPTS	CABARET PERMIT- ROB BEN'S	[redacted]
	TOTAL DUE:	[redacted]

CHECK : [redacted]   REF NUM: [redacted]

TENDERED [redacted]   CHANGE $.00

Cashier Hours (Excluding Holidays): Monday - Friday 9am-5pm.

KECIA JOHNSON

115

90-7526/3211
726

7/26/21
Date

Pay to the Order of City of Greenville

Golden1 golden1.com
Credit Union

For Rob Ben's Cabaret