# 2001 UNIFORM BUSINESS REPORT (UBR)

1082

0068694

DOCUMENT # M78217

1. Entity Name

HEALTH CARE SERVICES OF MISSISSIPPI, INCORPORATE

FILED

01 MAY 11 PM 3:58

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DO NOT WRITE IN THIS SPACE

| Principal Place of Business | Mailing Address |
|---|---|
| %STEPHEN P. GRIGGS<br>4506 L. B. MCLEOD RD.. #F<br>ORLANDO FL 32811 | %STEPHEN P. GRIGGS<br>4506 L. B. MCLEOD RD.. #F<br>ORLANDO FL 32811 |

| 2. Principal Place of Business | 3. Mailing Address |
|---|---|
| 2600 Technology Dr. | P. O. Box 53-6576 |
| Suite 300 (Suite, Apt. #, etc.) | Suite, Apt. #, etc. |
| Orlando, FL (City-State-Zip) | Orlando, FL (City-State-Zip) |
| 32804 County USA | 32853-6576 Country USA |

4. FEI Number 59-2893038 ☐ Applied For ☐ Not Applicable

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

| 6. Name and Address of Current Registered Agent | 7. Name and Address of New Registered Agent |
|---|---|
| CORPORATION SERVICE COMPANY<br>1201 HAYS STREET<br>TALLAHASSEE FL 32301 | Name<br>Street Address (P.O. Box Number is Not Acceptable)<br>City **FL** Zip Code |

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.

LS

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

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) ☒

**FILE NOW! FEE IS $150.00**
**After MAY 1, 2001 Fee will be $550.00**
**Make Check Payable to Department of State**

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

| 11. OFFICERS AND DIRECTORS | | | 12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | |
|---|---|---|---|---|
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | DP<br>GRIGGS, STEPHEN P<br>4506 LB MCLEOD RD STE F<br>ORLANDO FL 32811 | ☐ Delete | Stephen D. Linehan<br>2600 Technology Dr., Suite 300<br>Orlando, FL 32804 | ☒ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | VP<br>ZIOMEK, JANET L<br>4506 L.B. MCLEOD RD., SUITE F<br>ORLANDO FL 32811 | ☐ Delete | 2600 Technology Dr., Suite 300<br>Orlando, FL 32804 | ☒ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | S<br>NOVELL, N. SCOTT<br>4506 L.B. MCLEOD RD., SUITE F<br>ORLANDO FL 32811 | ☐ Delete | 2600 Technology Dr., Suite 300<br>Orlando, FL 32804 | ☒ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | D<br>LEVIN, MARC<br>910 RIDGEBROOK ROAD<br>SPARKS GLENCOE MD 21152 | ☐ Delete | 300004212553--1 | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | D<br>ELKINS, MARSHALL<br>910 RIDGEBROOK ROAD<br>SPARKS GLENCOE MD 21152 | ☐ Delete | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Delete | | ☐ Change ☐ Addition |

CR2E034 (10/00)

13. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(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 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

4/20/2001 (407) 822-4600

**SIGNATURE:** _____
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

202

ACCOUNT NO. : 072100000032

REFERENCE : 147611 7120726

AUTHORIZATION : Patricia Piggott

COST LIMIT : $550.00

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ORDER DATE : May 11, 2001

ORDER TIME : 12:19 PM

ORDER NO. : 147611-030

CUSTOMER NO: 7120726

CUSTOMER: Ms. Dawn Dreghorn
Rotech Medical Corporation
Suite 300
2600 Technology Drive
Orlando, FL 32804

RECEIVED
2001 MAY 11 PM 12:57
DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
NOT ACCEPTED TO ACKNOWLEDGE SUFFICIENCY OF FILING

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ANNUAL REPORT FILING

NAME: HEALTH CARE SERVICES OF MISSISSIPPI, INCORPORATED

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

_____ CERTIFIED COPY
XX PLAIN STAMPED COPY
_____ CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Susie Knight-EXT#1156

EXAMINER'S INITIALS: _____