


2007 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Feb 15, 2007 08:00 A
Secretary of State

JAN 29 2007

DOCUMENT # P98000058388			
1. Entity Name SURGERY CENTER OF OKEECHOBEE, INC.			
Principal Place of Business 1655 HIGHWAY 441 NORTH OKEECHOBEE FL 34972 US		Mailing Address 1655 HIGHWAY 441 NORTH OKEECHOBEE FL 34972 US	
2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country
6. Name and Address of Current Registered Agent		7. Name and Address of New Registered Agent	
RAPPEL, ROBERT 5070 HWY A1A - STE 221 C/O RAPPEL & RAPAE VERO BEACH FL 32960-4230		Name	
		Street Address (P.O. Box Number is Not Acceptable)	
		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. I am familiar with, and accept the obligations of registered agent.			
SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating)			
Signature, typed or printed name of registered agent and title if applicable. _____ DATE _____			



1st MOORE CR2E034 (10/06)

4. FEI Number 65-0847931	Applied For
	Not Applicable

5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
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FILE NOW!!! FEE IS \$150.00
After May 1, 2007 Fee Will Be \$550.00
Make Check Payable to Florida Department of State

9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/>	\$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	PD LANZA, JOHN M.D. <input type="checkbox"/> Delete 200 19TH DRIVE OKEECHOBEE FL 34972	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition U00000637028 02/26/07-80046-001 150.00
TITLE NAME STREET ADDRESS CITY - ST - ZIP	STD JAMES, RICHARD M.D. <input type="checkbox"/> Delete 245 19TH DRIVE OKEECHOBEE FL 34972	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D CHANG, JOHN M.D. <input type="checkbox"/> Delete 235 N.E. 19TH DRIVE OKEECHOBEE FL 34972	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D KURESHI, ZAFAR M.D. <input type="checkbox"/> Delete 214 N.E. 19TH DRIVE OKEECHOBEE FL 34972	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D GARCIA, MANUEL M.D. <input type="checkbox"/> Delete 306 N.E. 19TH DRIVE OKEECHOBEE FL 34972	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D LEVINE, MARC M.D. <input type="checkbox"/> Delete P.O. BOX 494H DRIVE OKEECHOBEE FL 34972	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 119, 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 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered

SIGNATURE: _____ **JOHN LANZA, M** **2/10/07** **863-357-6200**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #