FILE ON OR BEFORE DECEMBER 31, 1996 OR PARTNERSHIP WILL BE SUBJECT TO REVOCATION AND $500 PENALTY FEE

LIMITED PARTNERSHIP
ANNUAL REPORT
1997

FLORIDA DEPARTMENT OF STATE
Sandra Mortham
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
97 JAN -9 AM 10:13

1. Name of Limited Partnership

1a. DOCUMENT # **A95000000044**

MARTIN MEMORIAL SURGERY CENTER, LTD.

Mailing Address	Principal Office Address
509 RIVERSIDE DRIVE STUART FL 34994	509 RIVERSIDE DRIVE STUART FL 34994

3. Date Formed or Registered: 01/09/1995

3a. Date of Last Report: 02/27/1996

4. State or Country of Formation: FL

5a. Capital Contributions as Shown on record.: $900,000.00

5b. Amount of Capital Contributions in FLORIDA to date:

6. FEI Number: 65-0556038 ☐ Applied For ☐ Not Applicable

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

8. Make check payable to: Dept. of State (See reverse side for fee information)

2. Mailing Address	**2a.** Principal Office Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip Country	Zip Country

9. Name and Address of Current Registered Agent	**10.** If changed, new Registered Agent/Office
CORPORATION INFORMATION SERVICES, INC. 1201 HAYS STREET TALLAHASSEE FL 32301	Name Street Address (P.O. Box Number Is Not Acceptable) Suite, Apt. #, etc. City FL Zip Code

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10a. Pursuant to the provisions of sections 620.1051 and 620.192, Florida Statutes, the above-named limited partnership organized or registered under the laws of the State of Florida, submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by its general partner(s). I hereby accept the appointment of registered agent. I am familiar with, and accept the obligations of section 620.192, Florida Statutes.

SIGNATURE (Registered Agent Accepting Appointment) _____ DATE _____

A GENERAL PARTNER THAT IS A CORPORATION, LIMITED PARTNERSHIP OR OTHER BUSINESS ENTITY MUST BE REGISTERED AND ACTIVE WITH THIS OFFICE.

11. Name(s) of General Partner(s)	**11a.** Address of Each General Partner (Do NOT Use Post Office Box Numbers)	**11b.** City, State & Zip Code	**11c.** Registration/ Document Number
COASTAL CARE CORPORATION	509 RIVERSIDE DRIVE	STUART FL 34994	706843

Note: General partners MAY NOT be changed on this form; an amendment must be filed to change a general partner.

12. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), Florida Statutes. I release the Division of Corporations from any liability of non-compliance with Section 119.07(3)(k) in the event that the information supplied is deemed exempt from public access. I further certify that the information indicated on this annual report is true and accurate and that my signature shall have the same legal effects as if made under oath; I further certify that I am a General Partner of the limited partnership, receiver or trustee empowered to execute this report as required by chapter 620, Florida Statutes.

SIGNATURE RM Nan PRES/CEO DATE 12/12/96

Typed or Printed Name of General Partner Signing Form _____ Daytime Telephone Number _____

CR2E003 (6/96)

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