
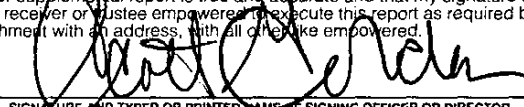


**2004 FOR PROFIT CORPORATION ANNUAL REPORT (AR)**

**FILED**  
**Mar 29, 2004 8:00 am**  
**Secretary of State**

03-29-2004 90402 019 \*\*\*150.00

|   |                             |                                 |   |   |                                   |           |          |
|---|-----------------------------|---------------------------------|---|---|-----------------------------------|-----------|----------|
| <b>DOCUMENT # K56381</b>  |                             |                                 |   |                |                                   |           |          |
| 1. Entity Name<br><b>KISSIMMEE SURGERY CENTER, INC.</b>   |                             |                                 |   |   |                                   |           |          |
| Principal Place of Business<br>2275 N. CENTRAL AVE.<br>KISSIMMEE FL 34741<br>US   |                             |                                 | Mailing Address<br>2275 N. CENTRAL AVE.<br>KISSIMMEE FL 34741<br>US   |   |                                   |           |          |
| 2. Principal Place of Business  |                             | 3. Mailing Address              |   |   |                                   |           |          |
| Suite, Apt. #, etc.   |                             | Suite, Apt. #, etc.             |   |   |                                   |           |          |
| City & State  |                             | City & State                    |   | 4. FEI Number<br><b>59-2930845</b>  |                                   |           |          |
| Zip   | Country                     | Zip                             | Country   | 5. Certificate of Status Desired <input type="checkbox"/> <b>\$8.75 Additional Fee Required</b> |                                   |           |          |
| 6. Name and Address of Current Registered Agent   |                             |                                 | 7. Name and Address of New Registered Agent   |   |                                   |           |          |
| <b>SCOTT, GORDON M.D.</b><br><b>604 OAK COMMONS BLVD.</b><br><b>KISSIMMEE FL 34741</b>  |                             |                                 | Name  |   |                                   |           |          |
|   |                             |                                 | Street Address (P.O. Box Number is Not Acceptable)  |   |                                   |           |          |
|   |                             |                                 | City  |   |                                   | <b>FL</b> | 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) DATE _____   |                             |                                 |   |   |                                   |           |          |
| <b>FILE NOW!!! FEE IS \$150.00</b><br><b>After May 1, 2004 Fee will be \$550.00</b><br><b>Make Check Payable to Florida Department of State</b>   |                             |                                 | 9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be Added to Fees</b> |   |                                   |           |          |
| 10. OFFICERS AND DIRECTORS  |                             |                                 | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11   |   |                                   |           |          |
| TITLE   | MD                          | <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change   | <input type="checkbox"/> Addition |           |          |
| NAME  | GORDON, SCOTT               |                                 | NAME  |   |                                   |           |          |
| STREET ADDRESS  | 604 OAK COMMONS BLVD.       |                                 | STREET ADDRESS  |   |                                   |           |          |
| CITY-ST-ZIP   | KISSIMMEE FL 34741          |                                 | CITY-ST-ZIP   |   |                                   |           |          |
| TITLE   | MD                          | <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change   | <input type="checkbox"/> Addition |           |          |
| NAME  | AGUSTINES, MANUEL           |                                 | NAME  |   |                                   |           |          |
| STREET ADDRESS  | 505 W. OAK STREET, STE. 202 |                                 | STREET ADDRESS  |   |                                   |           |          |
| CITY-ST-ZIP   | KISSIMMEE FL 34741          |                                 | CITY-ST-ZIP   |   |                                   |           |          |
| TITLE   | MD                          | <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change   | <input type="checkbox"/> Addition |           |          |
| NAME  | ESTRADA, NAPOLEON           |                                 | NAME  |   |                                   |           |          |
| STREET ADDRESS  | 812 W. OAK STREET           |                                 | STREET ADDRESS  |   |                                   |           |          |
| CITY-ST-ZIP   | KISSIMMEE FL 34741          |                                 | CITY-ST-ZIP   |   |                                   |           |          |
| TITLE   |                             | <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change   | <input type="checkbox"/> Addition |           |          |
| NAME  |                             |                                 | NAME  |   |                                   |           |          |
| STREET ADDRESS  |                             |                                 | STREET ADDRESS  |   |                                   |           |          |
| CITY-ST-ZIP   |                             |                                 | CITY-ST-ZIP   |   |                                   |           |          |
| TITLE   |                             | <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change   | <input type="checkbox"/> Addition |           |          |
| NAME  |                             |                                 | NAME  |   |                                   |           |          |
| STREET ADDRESS  |                             |                                 | STREET ADDRESS  |   |                                   |           |          |
| CITY-ST-ZIP   |                             |                                 | CITY-ST-ZIP   |   |                                   |           |          |
| TITLE   |                             | <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change   | <input type="checkbox"/> Addition |           |          |
| NAME  |                             |                                 | NAME  |   |                                   |           |          |
| STREET ADDRESS  |                             |                                 | STREET ADDRESS  |   |                                   |           |          |
| CITY-ST-ZIP   |                             |                                 | CITY-ST-ZIP   |   |                                   |           |          |
| 12. 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 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered. |                             |                                 |   |   |                                   |           |          |
| SIGNATURE:   |                             | Date: <b>3-24-04</b>            |   | Daytime Phone #: <b>407-870-0573</b>  |                                   |           |          |
| SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR  |                             |                                 |   |   |                                   |           |          |

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MOORE CR2E034 (11/03)