


**2004 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED
Sep 23, 2004 8:00 am
Secretary of State

09-23-2004 90069 013 ****55.00

DOCUMENT # L03000041185 1. Entity Name SOUTH BEACH MEDICAL INSTITUTE, LLC					
Principal Place of Business 7000 SW 62 AVE, STE 100 SOUTH MIAMI, FL 33143-4717			Mailing Address 7000 SW 62 AVE, STE 100 SOUTH MIAMI, FL 33143-4717		
2. Principal Place of Business		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country	4. FEI Number 07132004 Chg-LLC CR2E083 (10/03)	
5. Certificate of Status Desired <input checked="" type="checkbox"/> \$5.00 Additional Fee Required				<input checked="" type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent			7. Name and Address of New Registered Agent		
LESTER, PAUL A 201 ALHAMRA CIR, STE 601 CORAL GABLES, FL 33134			Name Street Address (P.O. Box Number is Not Acceptable) City <div style="display: flex; justify-content: space-between;"> FL Zip Code </div>		
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 registering) DATE _____					
Filing Fee is \$50.00 Due by September 8, 2004				Make check payable to Florida Department of State	
9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change	<input checked="" type="checkbox"/> Addition	
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change	<input type="checkbox"/> Addition	
11. 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 is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 606, Florida Statutes.					
SIGNATURE: _____		Date: 8/1/04.		Daytime Phone #: 305 7400994	
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE					

24082106





Attachment
24086106

FLORIDA DEPARTMENT OF STATE

Glenda E. Hood

Secretary of State

September 2, 2004

SOUTH BEACH MEDICAL INSTITUTE, LLC
7000 SW 62 AVE, STE 100
SOUTH MIAMI, FL 33143-4717

Subject: -SOUTH BEACH MEDICAL INSTITUTE, LLC-

Reference Number: L03000041185

Please be advised, we have received your annual report/uniform business report; however, the report has not been filed and a copy is being returned for the following correction(s):

The fee to file the enclosed annual report/uniform business report is \$50.00. If a certificate of status is desired, please add an additional \$5.00.

need
\$55.

**TO AVOID THE ADMINISTRATIVE DISSOLUTION/REVOCATION,
PLEASE RETURN THE CORRECTED REPORT TO: DIVISION OF
CORPORATIONS, P.O. BOX 6478, TALLAHASSEE, FLORIDA 32314
WITHIN 30 DAYS OF THE DATE OF THIS LETTER.**

If you have additional questions or need further assistance, please call the Division of Corporations at (850) 245-6051.

/RH

ANNUAL REPORTS SECTION