


**FILED**  
**May 18, 2007 8:00 am**  
**Secretary of State**

05-18-2007 90221 025 \*\*\*\*50.00

**2007 LIMITED LIABILITY COMPANY  
ANNUAL REPORT**

<b>DOCUMENT # L04000011627</b>					
1. Entity Name OCALA REGIONAL MEDICAL CENTER ANESTHESIOLOGY, L.L.C.					
Principal Place of Business 1515 E. SILVER SPRINGS BLVD. SUITE 132 OCALA, FL 34470		Mailing Address 1515 E. SILVER SPRINGS BLVD. SUITE 132 OCALA, FL 34470			
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	4. FEI Number 90-0143960	
				Applied For Not Applicable	
5. Certificate of Status Desired <input type="checkbox"/>				\$5.00 Additional Fee Required	
6. Name and Address of Current Registered Agent  GASSMAN, ALAN S 1245 COURT ST, STE 102 CLEARWATER, FL 33756				7. Name and Address of New Registered Agent 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) DATE _____					
Filing Fee is \$50.00 Due by September 14, 2007		Make check payable to Florida Department of State			
9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM MECCE, DANIEL A M.D. 1515 E SILVER SPRINGS BOULEVARD SUITE 132 OCALA, FL 34470 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR TURNER, EUGENE M.D. 1515 E SILVER SPRINGS BOULEVARD SUITE 132 OCALA, FL 34470 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR REED, TIMOTHY T M.D. 1515 E SILVER SPRINGS BOULEVARD SUITE 132 OCALA, FL 34470 <input checked="" type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	James W. Darling M.D. 1515 E. Silver Springs Blvd. Ste 132 Ocala, Florida 34470 <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition		
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		
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		
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 exemptions contained in Chapter 119, 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 608, Florida Statutes.					
SIGNATURE: <u>Daniel A. Mucca M.D. Managing Member</u> SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE			Date: <u>5/1/07</u> Daytime Phone #		