


2008 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Apr 03, 2008 8:00 am
Secretary of State

04-03-2008 90073 006 ***138.75

| | |
|--|---|
| DOCUMENT # L04000090053 |  |
| 1. Entity Name CAPE OUTPATIENT SURGICAL TEAM, LLC | |

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|--|--|
| Principal Place of Business 6981 LAKE DEVONWOOD DRIVE FORT MYERS, FL 33908 | Mailing Address 6981 LAKE DEVONWOOD DRIVE FORT MYERS, FL 33908 |
|--|--|

| | | | |
|--|---------|---------------------|---------|
| 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 |



01082008 Chg-LLC CR2E083 (12/06)

| | | |
|---|--|--|
| 4. FEI Number 20-2001683 | | Applied For <input type="checkbox"/> Not Applicable |
| 5. Certificate of Status Desired <input type="checkbox"/> | | \$5.00 Additional Fee Required |

| | | | |
|--|--|---|--|
| 6. Name and Address of Current Registered Agent | | 7. Name and Address of New Registered Agent | |
| GREEN, BRUCE D 1520 ROYAL PALM SQUARE BOULEVARD STE 320 FORT MYERS, FL 33919 | | 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 _____

| | |
|---|---|
| FILE NOW!!! FEE IS \$138.75 After May 1, 2008 Fee will be \$538.75 | Make check payable to: Florida Department of State |
|---|---|

| 9. MANAGING MEMBERS/MANAGERS | | 10. ADDITIONS/CHANGES | |
|--|---|--|---|
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | MGRM KAGAN M D, JOHN C 6981 LAKE DEVONWOOD DR FORT MYERS, FL 33908 <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 |
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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 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: X

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #

1/14/08