

# 2006 LIMITED LIABILITY COMPANY ANNUAL REPORT

**FILED**  
**Apr 18, 2006 8:00 am**  
**Secretary of State**

04-03-2006 90076 002 \*\*\*150.00

|  |  |                                 |   |  |   |
|--|--|---------------------------------|---|--|---|
| <b>DOCUMENT # L05000111745</b><br>1. Entity Name<br><b>PK HEALTH SERVICES, L.L.C.</b>  |  |                                 |   |  |   |
| Principal Place of Business<br><b>4113 LITTLE ROAD, UNIT 301<br/>NEW PORT RICHEY, FL 34655</b>   |  |                                 | Mailing Address<br><b>6133 OAK RIDGE AVENUE<br/>NEW PORT RICHEY, FL 34653</b>   |  |   |
| 2. Principal Place of Business<br>Suite, Apt. #, etc.  |  |                                 | 3. Mailing Address<br>Suite, Apt. #, etc.   |  |   |
| City & State   |  |                                 | City & State  |  |   |
| Zip  |  | Country                         |   | Zip  |   |
| Country  |  | Country                         |   | 4. FEI Number<br><b>20-3758549</b>                     |   |
| 5. Certificate of Status Desired <input type="checkbox"/> \$5.00 Additional Fee Required   |  |                                 |   | Applied For<br><input type="checkbox"/> Not Applicable |   |
| 6. Name and Address of Current Registered Agent<br><br><b>KLEIN, PATRICK R<br/>6127 OAK RIDGE AVENUE<br/>NEW PORT RICHEY, FL 34653</b>   |  |                                 | 7. Name and Address of New Registered Agent<br>Name<br>Street Address (P.O. Box Number is Not Acceptable)<br>City<br><div style="display: flex; justify-content: space-between;"> <span><b>FL</b></span> <span>Zip Code</span> </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 reinstating) _____ DATE _____  |  |                                 |   |  |   |
| Filing Fee is \$50.00<br>Due by May 1, 2006  |  |                                 |   | Make check payable to<br>Florida Department of State   |   |
| 9. MANAGING MEMBERS/MANAGERS   |  |                                 | 10. ADDITIONS/CHANGES   |  |   |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP   | MGR<br>KLEIN, PATRICK R<br>6127 OAK RIDGE AVENUE<br>NEW PORT RICHEY, FL 34653  | <input type="checkbox"/> Delete |   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP         | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP   | MGR<br>PIERCE, DEBORAH L<br>6133 OAK RIDGE AVENUE<br>NEW PORT RICHEY, FL 34653 | <input type="checkbox"/> Delete |   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP         | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP   |  | <input type="checkbox"/> Delete |   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP         | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP   |  | <input type="checkbox"/> Delete |   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP         | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP   |  | <input type="checkbox"/> Delete |   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP         | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP   |  | <input type="checkbox"/> Delete |   | TITLE<br>NAME<br>STREET ADDRESS<br>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>Deborah L Pierce</u>   |  |                                 | <u>3/31/06 727-846-0467</u>   |  |   |
| <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE</small>   |  |                                 |   |  |   |

ATTACHMENT

30005416

#L05000111745

April 14, 2006

PK Health Services, LLC  
6133 Oak Ridge Avenue  
New Port Richey, FL 34653

Subject: PK Health Services, LLC

Reference Number: L05000111745

Florida Department of State  
Division of Corporations  
Annual Report Section  
P.O. Box 6478  
Tallahassee, FL 32314

Dear Sirs:

Please find enclosed the copy of the annual report which you recently sent to me. For your reference, I am attaching a copy of your accompanying correspondence.

Per your request, I have supplied the Federal Employer Identification (FEI) number in Block 4 of the form.

I trust that the annual report will now be filed.

If you need any additional information, you may contact me at (727) 846-0467.

Thank you for your assistance.



Deborah L. Pierce, Manager  
PK Health Services