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FILED
Feb 17, 2003 8:00 am
Secretary of State

01-10-2003 90059 025 ***163.75

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P00000071117

1. Entity Name
KINGS POINT MEDICAL CENTER, INC.

Principal Place of Business
~~8155 N. PINE ISLAND RD.~~
~~TAMARAC FL 33321~~

Mailing Address
P.O. BOX 140777
CORAL GABLES FL 33114-0777

FEE 06

☐ CHECK HERE IF MAKING CHANGES

2. Principal Place of Business	3. Mailing Address
7574 S. W. 77th Court	
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: MIAMI, FLORIDA	City & State
Zip: 33143 / Country: US	Zip / Country

4. FEI Number ~~APPLIED FOR~~ 06-1675278 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☒ $8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

GONZALEZ, CECILIO F
7574 S. W. 77TH COURT
MIAMI FL 33143

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 ____________________ Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE

FILE NOW!!! FEE IS $150.00
After May 1, 2003 Fee will be $550.00
Make Check Payable to Florida Department of State

9. Election Campaign Financing Trust Fund Contribution. ☒ $5.00 May Be Added to Fees

10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE	D ☐ Delete	TITLE	☐ Change ☐ Addition
NAME	GONZALEZ, CECILIO F	NAME	
STREET ADDRESS	7574 S. W. 77TH COURT	STREET ADDRESS	
CITY-ST-ZIP	MIAMI FL 33143	CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ 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: Cecilio F. Gonzalez, DIRECTOR — 01-08-2003 — (305)662-9000
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR / Date / Daytime Phone #

CR2E034 (10/02)

Attachment

****
*** ERROR TX REPORT ***
****

5507950

P0000071117

TX FUNCTION WAS NOT COMPLETED

TX/RX NO	4012
CONNECTION TEL	913055964484
SUBADDRESS	
CONNECTION ID	
ST. TIME	01/31 16:29
USAGE T	00'00
PGS.	0
RESULT	NG

0 #018

JAN-28-03 TUE 1:00 PM FAX NO. 305 596 4484 P. 2

TT 1-31-03

Form **SS-4** (Rev. December 2001)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ See separate instructions for each line. ▶ Keep a copy for your records.

EIN

OMB No. 1545-0003

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
KINGS POINT MEDICAL CENTER, INC.

06-1675278

2 Trade name of business (if different from name on line 1)

3 Executor, trustee, "care of" name
Cecilio F. Gonzalez, Director

4a Mailing address (room, apt., suite no. and street, or P.O. box)
P.O.Box 14-0777

5a Street address (if different) (Do not enter a P.O. box.)
7574 S. W. 77th Court

4b City, state, and ZIP code
Coral Gables, Fl. 33114-0777

5b City, state, and ZIP code
Miami, Florida 33143

6 County and state where principal business is located
Dade County, Florida

7a Name of principal officer, general partner, grantor, owner, or trustor
Cecilio F. Gonzalez

7b SSN, ITIN, or EIN
267-72-8725

8a Type of entity (check only one box)

- ☐ Sole proprietor (SSN) ___
- ☐ Partnership
- ☒ Corporation (enter form number to be filed) ▶ 1120
- ☐ Personal service corp.
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☐ Other (specify) ▶
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (SSN)
- ☐ Trust (SSN of grantor)
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) ▶

8b If a corporation, name the state or foreign country (if applicable) where incorporated — State: FLORIDA — Foreign country:

9 Reason for applying (check only one box)

- ☒ Started new business (specify type) ▶ HEALTHCARE CONSULTANTS
- ☐ Hired employees (Check the box and see line 12.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☐ Banking purpose (specify purpose) ▶
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Created a pension plan (specify type) ▶

10 Date business started or acquired (month, day, year)
JANUARY - 2003

11 Closing month of accounting year
December 31st

12 First date wages or annuities were paid or will be paid (month, day, year). Note: *If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year)* ▶ NOT APPLICABLE

13 Highest number of employees expected in the next 12 months. Note: *If the applicant does not expect to have any employees during the period, enter "-0-."* ▶

Agricultural	Household	Other
-0-	-0-	1

14 Check one box that best describes the principal activity of your business.

- ☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Wholesale–agent/broker
- ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Accommodation & food service ☐ Wholesale–other ☐ Retail
- ☒ Other (specify) HEALTHCARE CONSULTANTS

15 Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided.
HEALTHCARE CONSULTING SERVICES

16a Has the applicant ever applied for an employer identification number for this or any other business? ☐ Yes ☒ No
Note: *If "Yes," please complete lines 16b and 16c.*

16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above.