


**2005 LIMITED LIABILITY COMPANY ANNUAL REPORT**

**FILED**  
**Feb 23, 2005 08:00 AM**  
**Secretary of State**

**DOCUMENT # M03000002341**

1. Entity Name  
 SOVEREIGN HEALTHCARE OF JACKSONVILLE, LLC



Principal Place of Business SOUTHERN HEALTHCARE MANAGEMENT, LLC 101 SUNNYTOWN ROAD, STE. 201 CASSELBERRY, FL 32707 US	Mailing Address SOUTHERN HEALTHCARE MANAGEMENT, LLC 101 SUNNYTOWN ROAD, STE. 201 CASSELBERRY, FL 32707 US
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**DO NOT WRITE IN THIS SPACE**



01032005No Chg-LLC CR2E083 (10/03)

4. FEI Number 20-0185133	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	<b>\$5.00</b> Additional Fee Required

6. Name and Address of Current Registered Agent

NATIONAL CORPORATE RESEARCH, LTD., INC.  
 103 NORTH MERIDIAN STREET  
 TALLAHASSEE, FL 32301

**DO NOT WRITE IN THIS SPACE**

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

**Filing Fee is \$50.00**  
**Due by May 1, 2005**

9. MANAGING MEMBERS/MANAGERS

TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGRM SOVEREIGN HEALTHCARE, INC. 101 SUNNYTOWN RD., STE 201 CASSELBERRY, FL 32707
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 02/23/05-80012-018 50.00

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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 608, Florida Statutes.

SIGNATURE: David L. Laza Date: 1/3/05  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE