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Apr 05, 2004 8:00 am
Secretary of State
03-22-2004 90420 013 ****50.00

2004 LIMITED LIABILITY COMPANY ANNUAL REPORT

DOCUMENT # M03000002326

1. Entity Name
SOVEREIGN HEALTHCARE OF FLORIDA, LLC

Principal Place of Business	Mailing Address
205 PRESWICK PARK DRIVE NEWMAN, GA 30265	205 PRESWICK PARK DRIVE NEWMAN, GA 30265

2. Southern Healthcare Management, LLC.
101 Sunnytown Road, Suite 201
Casselberry, Florida 32707

02122004 Chg-LLC CR2E083 (10/03)

4. FEI Number: 20-0936335 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ $5.00 Additional Fee Required

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
NATIONAL CORPORATE RESEARCH, LTD., INC. 103 N. MERIDIAN STREET TALLAHASSEE, FL 32301	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 ____________________ 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, 2004

Make check payable to Florida Department of State

9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM SOVEREIGN HEALTHCARE, INC. 205 PRESWICK PARK DRIVE NEWMAN, GA 30265	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	Southern Healthcare Mgmt. LLC 101 Sunnytown Road, Suite 201 Casselberry, Florida 32707	☑ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition

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: Daniel L. Hayes
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #

Attachment
#M03000002396
340026U5

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 20-0936335 OMB No. 1545-0003

1* Legal name of entity (or individual) for whom the EIN is being requested
Sovereign Healthcare of Florida LLC

2 Trade name of business (if different from name on line 1)	3 Executor, trustee, "care of" name William J Krystopowicz
4a* Mailing address (room, apt., suite no. and street, or P.O. box) 101 Sunny Town Road Suite 201	5a Street address (if different) (Do not enter a P.O. box)
4b* City, state, and ZIP code Casselberry FL 32707 - 3862	5b City, state, and ZIP code -

6* County and state where principal business is located
County Seminolle State FL

7a* Name of principal officer, general partner, grantor, owner, or trustor William J Krystopowicz	7b* SSN, ITIN, EIN 181-44-0506

8a* Type of entity (check only one)

- ☐ Sole Proprietor (SSN)
- ☑ Partnership
- ☐ Corporation (enter form number to be filed) ▶
- ☐ Personal Service
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☐ Other (specify) ▶
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (SSN)
- ☐ Trust (SSN of grantor)
- ☐ National Guard
- ☐ Farmers' cooperative
- ☐ REMIC
- Group Exemption N0. (GEN) ▶
- ☐ State/local government
- ☐ Federal government/military
- ☐ Indian tribal government/enterprises

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

9* Reason for applying (check only one)

- ☑ Started new business (specify type) ▶ Limited Liability Co
- ☐ 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) JUL 21 2003	11* Closing month of accounting year DEC

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)* ▶

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

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

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

15* Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided.
Management Company

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.
Legal name ▶
Trade name ▶

16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (month, day, year)	City and state where filed	Previous EIN
		-

Third Party Designee	Complete section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form	
	Designee's name Don Melton Address and ZIP code 101 Sunnytown Rd 201 Casselberry FL 32707 -	Designee's telephone number (include area code) (407) 830 - 5309 Designee's fax number (include area code) (407) 830 - 7952

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete. Name and title (type or print clearly)	Applicant's telephone number (include area code)