

**2003 LIMITED LIABILITY COMPANY
UNIFORM BUSINESS REPORT (UBR)**


FILED
Jan 21, 2003 8:00 am
Secretary of State

01-21-2003 90320 010 ****50.00

0046312

DOCUMENT # L01000002477

1. Entity Name
FIFTH FAIRWAY ADULT CARE LLC



Principal Place of Business Mailing Address
1020 CLAUDIA STREET **1020 CLAUDIA STREET**
NEW SMYRNA BEACH FL 32168 **NEW SMYRNA BEACH FL 32168**

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



CHECK HERE IF MAKING CHANGES

4. FEI Number **59-3703867** Applied For
 Not Applicable

5. Certificate of Status Desired **\$5.00 Additional Fee Required**

6. Name and Address of Current Registered Agent

HALL, MARK R
124 FAULKNER STREET
NEW SMYRNA BEACH FL 32168

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

FILE NOW!!! FEE IS \$50.00
Make Check Payable to Florida Department of State
Due By May 1, 2003

9. MANAGING MEMBERS / MANAGERS

TITLE	MGRM <input type="checkbox"/> Delete
NAME	CALLISON, JUDITH A
STREET ADDRESS	1020 CLAUDIA STREET
CITY-ST-ZIP	NEW SMYRNA BEACH FL 32168
TITLE	_____ <input type="checkbox"/> Delete
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____
TITLE	_____ <input type="checkbox"/> Delete
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____
TITLE	_____ <input type="checkbox"/> Delete
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____
TITLE	_____ <input type="checkbox"/> Delete
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____

10. ADDITIONS / CHANGES

TITLE	_____ <input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____
TITLE	_____ <input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____
TITLE	_____ <input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____
TITLE	_____ <input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	_____
STREET ADDRESS	_____
CITY-ST-ZIP	_____

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: *Judith A Callison* **1-7-03 (386) 426 0451**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #

CR2E083 (10/02)