


# 2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

**FILED**  
**Apr 29, 2005 8:00 am**  
**Secretary of State**


04-29-2005 90042 027 \*\*\*\*50.00

<b>DOCUMENT # L01000012563</b>	
1. Entity Name <b>FORT PIERCE HEALTH CARE ASSOCIATES, LLC</b>	

Principal Place of Business <b>611 SOUTH 13TH STREET FORT PIERCE, FL 34950</b>	Mailing Address <b>10210 HIGHLAND MANOR DRIVE, STE. 250 TAMPA, FL 33610</b>
---------------------------------------------------------------------------------------	------------------------------------------------------------------------------------

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

**20050765**



04262005 Chg-LLC CR2E083 (10/03)

4. FEI Number <b>58-2639439</b>	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> <b>\$5.00 Additional Fee Required</b>	

6. Name and Address of Current Registered Agent <b>CORPORATION SERVICE COMPANY 1201 HAYS STREET TALLAHASSEE, FL 32301-2525</b>	7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <b>FL</b> 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 \_\_\_\_\_ (NOTE: Registered Agent signature required when reinstating) DATE \_\_\_\_\_

<b>Filing Fee is \$50.00 Due by May 1, 2005</b>	<b>Make check payable to Florida Department of State</b>
-----------------------------------------------------	--------------------------------------------------------------

9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>MGRM EPSILON HEALTH CARE PROPERTIES, LLC 10210 HIGHLAND MANOR DRIVE STE. 250 TAMPA, FL 33610</b> <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>SOLE MEMBER EPSILON HEALTH CARE PROPERTIES, LLC 10210 HIGHLAND MANOR DR. STE. 250 TAMPA, FL 33610</b> <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS 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 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, F.S.

**SIGNATURE:** 

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

PATRICK DUPLANTIS,  
AUTHORIZED REPRESENTATIVE  
OF SOLE MEMBER  
(813) 744-2800 DAYTIME PHONE  
4/26/2005