


**2005 LIMITED LIABILITY COMPANY ANNUAL REPORT**

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

04-29-2005 90042 012 \*\*\*\*50.00

**DOCUMENT # L01000012576**

1. Entity Name  
**NORTH OKALOOSA HEALTH CARE ASSOCIATES, LLC**



Principal Place of Business  
**500 S. HOSPITAL DRIVE  
 CRESTVIEW, FL 32539**

Mailing Address  
**10210 HIGHLAND MANOR DRIVE STE. 250  
 TAMPA, FL 33610**

**20050780**



2. Principal Place of Business  
 Suite, Apt. #, etc.

3. Mailing Address  
 Suite, Apt. #, etc.

04262005 Chg-LLC CR2E083 (10/03)

City & State  
 Zip Country

4. FEI Number  
**58-2639467**

Applied For  
 Not Applicable

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

**6. Name and Address of Current Registered Agent**

**CORPORATION SERVICE COMPANY  
 1201 HAYS STREET  
 TALLAHASSEE, FL 32301-2525**

**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 \_\_\_\_\_ (NOTE: Registered Agent signature required when reinstating) DATE \_\_\_\_\_

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

**Make check payable to  
 Florida Department of State**


**9. MANAGING MEMBERS/MANAGERS**

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>MCRM EPSILON HEALTH CARE PROPERTIES, LLC 10210 HIGHLAND MANOR DR., STE. 250 TAMPA, FL 33610</b>	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete

**10. ADDITIONS/CHANGES**

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"/> Change <input type="checkbox"/> Addition
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"/> Change <input type="checkbox"/> Addition
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"/> 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 605, Florida Statutes.

**SIGNATURE:**   
 SIGNATURE AND TYPE 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