


2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

04-29-2005 90042 044 ****50.00
L01000012605

FILED

05 JUL 27 AM 10:58

SECRETARY OF STATE
TALLAHASSEE, FLORIDA
20050796

| | |
|---|---|
| DOCUMENT # L01000012605 |  |
| 1. Entity Name DELTONA HEALTH CARE ASSOCIATES, LLC | |

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| Principal Place of Business 1851 ELKCAM BLVD. DELTONA, FL 32725 US | Mailing Address 10210 HIGHLAND MANOR DRIVE STE. 250 TAMPA, FL 33610 US |
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|---|---|
| 2. Principal Place of Business Suite, Apt. #, etc. | 3. Mailing Address Suite, Apt. #, etc. |
|---|---|

| | |
|--------------|--------------|
| City & State | City & State |
|--------------|--------------|

| | | | |
|-----|---------|-----|---------|
| Zip | Country | Zip | Country |
|-----|---------|-----|---------|



04262005 Chg-LLC CR2E083 (10/03)

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|-----------------------------|-------------------------------|
| 4. FEI Number 58-2639432 | Applied For Not Applicable |
|-----------------------------|-------------------------------|

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| 5. Certificate of Status Desired <input type="checkbox"/> | \$5.00 Additional Fee Required |
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| 6. Name and Address of Current Registered Agent CORPORATION SERVICE COMPANY 1201 HAYS STREET TALLAHASSEE, FL 32301-2525 |
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| 7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code |
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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 | <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 | <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition |
| Managing Member EPSILON HEALTH CARE PROPERTIES, LLC 10210 HIGHLAND MANOR DR. STE. 250 TAMPA, FL 33610 | <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 |

400058202344
08/03/05--01051--016 **\$5.00

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 by the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 601

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