2007 LIMITED LIABILITY COMPANY
ANNUAL REPORT

FILED
Jul 13, 2007 08:00 AM
Secretary of State

DOCUMENT # L02000024189

1. Entity Name
THE CALA HILLS FAMILY CLINIC, LLC

Principal Place of Business	Mailing Address
2118 SW 20TH PLACE SUITE 102 OCALA, FL 34474 US	2118 SW 20TH PLACE SUITE 102 OCALA, FL 34474 US

DO NOT WRITE IN THIS SPACE

07062007 No Chg-LLC   CR2E083 (11/05)

4. FEI Number	Applied For
06-1651753	Not Applicable

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

6. Name and Address of Current Registered Agent

STRADER, CHESTER R
811 SE 44 AVE
OCALA, FL 34471

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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.
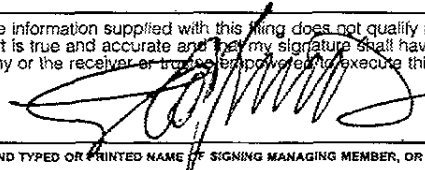
SIGNATURE_____

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

Filing Fee is $50.00
Due by September 14, 2007

9.   MANAGING MEMBERS/MANAGERS

TITLE	MGRM
NAME	CABAN, JR., EPHRAIM PRES.
STREET ADDRESS	2118 SW 20TH PLACE, SUITE 102
CITY-ST-ZIP	OCALA, FL 34474
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
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07/13/07-80009-022 50.00

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11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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: _____   2-6-07   352-291-1022

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE   Date   Daytime Phone #