

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

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10/2

DOCUMENT # L26268

1. Entity Name
NIGHTINGALE HOME HEALTH CARE, INC.



Principal Place of Business
**2600 TECHNOLOGY DR., STE 300
ORLANDO FL 32804**

Mailing Address
**P.O. BOX 53-6576
ORLANDO FL 32853-6576**

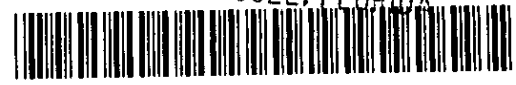
2. Principal Place of Business
Suite, Apt. #, etc.

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

City & State

Zip Country Zip Country

FILED
03 JAN 17 PM 3:42
SECRETARY OF STATE
TALLAHASSEE, FLORIDA



CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

**CORPORATION SERVICE COMPANY
1201 HAYS STREET
TALLAHASSEE FL 32301**

4. FEI Number **59-2973784** Applied For Not Applicable

5. Certificate of Status Desired **\$8.75 Additional Fee Required**

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 \$150.00
After May 1, 2003 Fee will be \$550.00
Make Check Payable to Florida Department of State

9. Election Campaign Financing Trust Fund Contribution. **\$5.00 May Be Added to Fees**

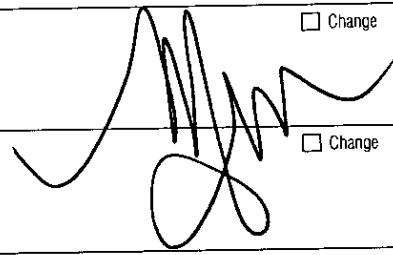
10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD LINEHAN, STEPHEN D 2600 TECHNOLOGY DR., STE 300 ORLANDO FL 32804	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	TO ZIOMEK, JANET L 2600 TECHNOLOGY DR., STE 300 ORLANDO FL 32804	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	SD MYERS, REBECCA L 2600 TECHNOLOGY DR., STE 300 ORLANDO FL 32804	<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

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD Philip L Carter 2600 Technology Dr, 300 Orlando, FL 32804	<input type="checkbox"/> Change <input checked="" 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

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12. 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 or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: _____ **1/15/03 407.822.4600 x4799**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/02)



zapz

ACCOUNT NO. : 072100000032
 REFERENCE : 897812 7355325
 AUTHORIZATION : *Patricia Pizano*
 COST LIMIT : \$ 150.00

ORDER DATE : January 17, 2003
 ORDER TIME : 11:59 PM
 ORDER NO. : 897812-135
 CUSTOMER NO: 7355325
 CUSTOMER: Gina Deloach
 Rotech Healthcare, Inc.
 Suite 300
 2600 Technology Drive
 Orlando, FL 32804

RECEIVED
 03 JAN 17 PM 2:31
 DEPARTMENT OF STATE
 DIVISION OF CORPORATIONS
 TALLAHASSEE, FLORIDA

ANNUAL REPORT FILING

NAME: NIGHTINGALE HOME HEALTH CARE, INC.

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

- CERTIFIED COPY
- XX PLAIN STAMPED COPY
- CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Sara Lea-EXT#1114

EXAMINER'S INITIALS:

[Handwritten Signature]