

2001. UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # M00000001456

1. Entity Name

STOMAD CENTERS CROSSWINDS CENTER, LLC

Principal Place of Business

**725 CONSHOHOCKEN STATE ROAD
BALA CYNWYD PA 19004**

Mailing Address

**725 CONSHOHOCKEN STATE ROAD
BALA CYNWYD PA 19004**

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

6. Name and Address of Current Registered Agent

**C T CORPORATION SYSTEM
1200 SOUTH PINE ISLAND ROAD
PLANTATION FL 33324**

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.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$50.00
Make Check Payable to Department of State**

9. MANAGING MEMBERS/MEMBERS

TITLE NAME **MGR** ☐ Delete
STOMAD CENTERS, INC.
STREET ADDRESS **725 CONSHOHOCKEN STATE ROAD**
CITY-ST-ZIP **BALA CYNWYD PA 19004**

TITLE NAME ☐ Delete
STREET ADDRESS
CITY-ST-ZIP

TITLE NAME ☐ Delete
STREET ADDRESS
CITY-ST-ZIP

TITLE NAME ☐ Delete
STREET ADDRESS
CITY-ST-ZIP

TITLE NAME ☐ Delete
STREET ADDRESS
CITY-ST-ZIP

TITLE NAME ☐ Delete
STREET ADDRESS
CITY-ST-ZIP

10. ADDITIONS/CHANGES

TITLE NAME ☐ Change ☐ Addition
100003745591--1
-02/21/01--01083--009
*******50.00 *****50.00**

TITLE NAME ☐ Change ☐ Addition
STREET ADDRESS
CITY-ST-ZIP

TITLE NAME ☐ Change ☐ Addition
STREET ADDRESS
CITY-ST-ZIP

TITLE NAME ☐ Change ☐ Addition
STREET ADDRESS
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TITLE NAME ☐ Change ☐ Addition
STREET ADDRESS
CITY-ST-ZIP

TITLE NAME ☐ Change ☐ Addition
STREET ADDRESS
CITY-ST-ZIP

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, Florida Statutes.

SIGNATURE:

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

Date

Daytime Phone #

(Stom 4286) (Crosser) Bank property

FILED

01 FEB 16 PM 4:29

SECRETARY OF STATE
TALLAHASSEE, FLORIDA



DO NOT WRITE IN THIS SPACE

51-0401588

4. FEI Number **APPLIED FOR** ☐ Applied For ☐ Not Applicable

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

CR2E083 (11/00)

1/22/01