


2004 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Apr 05, 2004 8:00 am
Secretary of State

03-22-2004 90420 013 ****50.00

DOCUMENT # M03000002326 1. Entity Name SOVEREIGN HEALTHCARE OF FLORIDA, LLC		
Principal Place of Business 205 PRESWICK PARK DRIVE NEWMAN, GA 30265		Mailing Address 205 PRESWICK PARK DRIVE NEWMAN, GA 30265
2. Southern Healthcare Management, LLC. 101 Sunnyside Road, Suite 201 Casselberry, Florida 32707		02122004 Chg-LLC CR2E083 (10/03) 4. FFI Number 20-0936335 <input type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable 5. Certificate of Status Desired <input type="checkbox"/> \$5.00 Additional Fee Required
6. Name and Address of Current Registered Agent NATIONAL CORPORATE RESEARCH, LTD., INC. 103 N. MERIDIAN STREET TALLAHASSEE, FL 32301		7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code
B. 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 reconstituting) _____ DATE: _____ <small>Signature, typed or printed name of registered agent and title if applicable.</small>		
Filing Fee is \$50.00 Due by May 1, 2004		Make check payable to Florida Department of State
9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM SOVEREIGN HEALTHCARE, INC. <input type="checkbox"/> Delete 205 PRESWICK PARK DRIVE NEWMAN, GA 30265	TITLE NAME STREET ADDRESS CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	Southern Healthcare Mgmt, LLC <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition 101 Sunnyside Road, Suite 201 Casselberry, Florida 32707
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<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)(f), 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: <u><i>James A. Hagan</i></u> <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE</small>		
Date _____ Daytime Phone # _____		

Attachment
#M030000002326
34002645

Form SS-4 (Rev. December 2001) Department of the Treasury Internal Revenue Service		Application for Employer Identification Number (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) ▶ See separate instructions for each line. ▶ Keep a copy for your records.		EIN 20-0936335 OMB No. 1545-0003	
1* Legal name of entity (or individual) for whom the EIN is being requested Sovereign Healthcare of Florida LLC					
2 Trade name of business (if different from name on line 1)			3 Executor, trustee, "care of" name William J Krystopowicz		
4a* Mailing address (room, apt., suite no. and street, or P.O. box) 101 Sunny Town Road Suite 201			5a Street address (if different) (Do not enter a P.O. box)		
4b* City, state, and ZIP code Casselberry FL 32707 - 3862			5b City, state, and ZIP code		
6* County and state where principal business is located County Seminolle State FL					
7a* Name of principal officer, general partner, grantor, owner, or trustor William J Krystopowicz			7b* SSN, ITIN, EIN 181-44-0506		
8a* Type of entity (check only one)					
<input type="checkbox"/> Sole Proprietor (SSN)		<input type="checkbox"/> Estate (SSN of decedent)		<input type="checkbox"/> State/local government	
<input checked="" type="checkbox"/> Partnership		<input type="checkbox"/> Plan administrator (SSN)		<input type="checkbox"/> Federal government/military	
<input type="checkbox"/> Corporation (enter form number to be filed) ▶		<input type="checkbox"/> Trust (SSN of grantor)		<input type="checkbox"/> Indian tribal government/enterprises	
<input type="checkbox"/> Personal Service		<input type="checkbox"/> National Guard			
<input type="checkbox"/> Church or church-controlled organization		<input type="checkbox"/> Farmers' cooperative			
<input type="checkbox"/> Other nonprofit organization (specify) ▶		<input type="checkbox"/> REMIC			
<input type="checkbox"/> Other (specify) ▶		Group Exemption NO. (GEN) ▶			
8b If a corporation, name the state or foreign country (if applicable) where incorporated		State		Foreign country	
9* Reason for applying (check only one)					
<input checked="" type="checkbox"/> Started new business (specify type) ▶ Limited Liability Co		<input type="checkbox"/> Banking purpose (specify purpose) ▶			
<input type="checkbox"/> Hired employees (Check the box and see line 12)		<input type="checkbox"/> Changed type of organization (specify new type) ▶			
<input type="checkbox"/> Compliance with IRS withholding regulations		<input type="checkbox"/> Purchased going business			
<input type="checkbox"/> Other (specify) ▶		<input type="checkbox"/> Created a trust (specify type) ▶			
		<input type="checkbox"/> Created a pension plan (specify type) ▶			
10* Date business started or acquired (month, day, year) JUL 21 2003			11* Closing month of accounting year DEC		
12 First date wages or annuities were paid or will be paid (month, day, year) <i>Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year)</i>					
13 Highest number of employees expected in the next twelve months <i>Note: If the applicant does not expect to have any employees during the period, enter "-0-"</i>				Agriculture 0	Household 0
				Other 0	
14* Check box that best describes the principal activity of your business					
<input type="checkbox"/> Construction		<input type="checkbox"/> Rental & leasing		<input type="checkbox"/> Health care & social assistance	
<input type="checkbox"/> Real estate		<input type="checkbox"/> Transportation & warehousing		<input type="checkbox"/> Accommodation & food service	
<input checked="" type="checkbox"/> Other (specify) - Management Company		<input type="checkbox"/> Manufacturing		<input type="checkbox"/> Finance & insurance	
		<input type="checkbox"/> Retail		<input type="checkbox"/> Wholesale-agent/broker	
				<input type="checkbox"/> Wholesale-other	
15* Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. Management Company					
16a* Has the applicant ever applied for an employer identification number for this or any other business? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>Note: If "Yes" please complete lines 16b and 16c</i>					
16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above. Legal name ▶ Trade name ▶					
16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (month, day, year) City and state where filed Previous EIN					
Complete section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form					
Third Party Designee		Designee's name Don Melton		Designee's telephone number (include area code) (407) 830 - 5309	
		Address and ZIP code 101 Sunnytown Rd 201 Casselberry FL 32707 -		Designee's fax number (include area code) (407) 830 - 7952	
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete. Name and title (type or print clearly)				Applicant's telephone number (include area code)	