


**2005 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED
Mar 31, 2005 08:00 AM
Secretary of State

DOCUMENT # L01000007845 1. Entity Name ST. AUGUSTINE HEALTH AND REHABILITATION, L.L.C.	
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Principal Place of Business 931 FAIRFAX PARK TUSCALOOSA, AL 35406	Mailing Address 931 FAIRFAX PARK TUSCALOOSA, AL 35406
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DO NOT WRITE IN THIS SPACE



01122005No Chg-LLC

CR2E083 (10/03)

4. FEI Number 63-1284540	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

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

**DO NOT WRITE
IN THIS SPACE**

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 May 1, 2005**

9. MANAGING MEMBERS/MANAGERS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGRM NORTHPORT HEALTH SERVICES OF FLORIDA,LLC 931 FAIRFAX PARK TUSCALOOSA, AL 35406
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03/31/05-80055-025 50.00

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IN THIS SPACE**

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: Christopher R Drivers, ASST Controller 11/2/05 (205)343-7363

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