


# 2007 LIMITED LIABILITY COMPANY ANNUAL REPORT

**FILED**  
**Apr 30, 2007 8:00 am**  
**Secretary of State**

04-30-2007 90054 023 \*\*\*\*50.00

<b>DOCUMENT # L03000017146</b>					
<b>1. Entity Name</b> SOUTHPPOINT HEALTH CARE ASSOCIATES, LLC					
<b>Principal Place of Business</b> 42 COLLINS AVE MIAMI BEACH, FL 33139			<b>Mailing Address</b> 10210 HIGHLAND MANOR DRIVE, SUITE 250 TAMPA, FL 33610		
<b>2. Principal Place of Business - No P.O. Box #</b> 10210 Highland Manor Drive		<b>3. Mailing Address</b> 303 Perimeter Center North			
Suite, Apt. #, etc. Suite 270		Suite, Apt. #, etc. Suite 500			
City & State Tampa, FL		City & State Atlanta, GA		03292007    Chg-LLC    CR2E083 (12/06)	
Zip 33610	Country US	Zip 30346	Country US	<b>4. FEI Number</b> 81-0612152	
<b>5. Certificate of Status Desired</b> <input type="checkbox"/> <b>\$5.00 Additional Fee Required</b>				Applied For Not Applicable	
<b>6. Name and Address of Current Registered Agent</b>  CORPORATION SERVICE COMPANY 1201 HAYS STREET TALLAHASSEE, FL 32301-2525			<b>7. Name and Address of New Registered Agent</b> Name Street Address (P.O. Box Number is Not Acceptable) City <b>FL</b> Zip Code		
<b>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.</b>					
SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating)    DATE _____					
<b>Filing Fee is \$50.00 Due by May 1, 2007</b>				<b>Make check payable to Florida Department of State</b>	
<b>9. MANAGING MEMBERS/MANAGERS</b>			<b>10. ADDITIONS/CHANGES</b>		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM ALPHA HEALTH CARE PROPERTIES, LLC 10210 HIGHLAND MANOR DRIVE, SUITE 250 TAMPA, FL 33610 <input type="checkbox"/> Delete		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"/> Delete		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"/> Delete		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"/> Delete		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"/> Delete		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"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
<b>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.</b>					
<b>SIGNATURE:</b> <u>Tracey C. Cosby</u> Tracey C. Cosby, Board Member of Alpha Health Care Properties, LLC					
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE    Date    Daytime Phone #					

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