

2000 UNIFORM BUSINESS REPORT (UBR)

APPROVED
AND
FILED

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DOCUMENT # L99000006374

1. Entity Name

SOUTH HERITAGE HEALTH & REHABILITATION CENTER, L

00 JUN 27 PM 3:02

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business

111 W MICHIGAN ST.
MILWAUKEE WI 53203

Mailing Address

111 W MICHIGAN ST.
MILWAUKEE WI 53203-2903



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business

718 LAKEVIEW AVE SOUTH
Suite, Apt. #, etc.

3. Mailing Address

Suite, Apt. #, etc.

City & State

ST PETERSBURG, FL

City & State

Zip

Country

33705

4. FEI Number

36-4321432

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$5.00 Additional
Fee Required

6. Name and Address of Current Registered Agent

LEXIS DOCUMENT SERVICES, INC.
3953 WW KELLEY RD.
TALLAHASSEE FL 32311

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 MGRM
STREET ADDRESS EXTENDICARE HEALTH FACILITIES, INC.
CITY- ST- ZIP 111 W MICHIGAN ST.
MILWAUKEE WI 53203

TITLE NAME
STREET ADDRESS
CITY- ST- ZIP

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TITLE NAME
STREET ADDRESS
CITY- ST- ZIP

10. ADDITIONS/CHANGES

TITLE NAME
STREET ADDRESS
CITY- ST- ZIP

TITLE NAME
STREET ADDRESS
CITY- ST- ZIP

TITLE NAME
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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 OR MANAGER

Date

Daytime Phone #

WALTER A. LEONOWICH 4/28/00 414/905-8438