


2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
May 05, 2005 8:00 am
Secretary of State

05-05-2005 90030 001 *1,400.00

DOCUMENT # L99000006379	
1. Entity Name ALPINE HEALTH AND REHABILITATION CENTER, LLC	

Principal Place of Business 111 W. MICHIGAN ST. MILWAUKEE, WI 53203	Mailing Address 111 W. MICHIGAN ST. MILWAUKEE, WI 53203
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30005595

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



04222005 Chg-LLC CR2E083 (10/03)

4. FEI Number 36-4321373		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		7. Name and Address of New Registered Agent	
LEXISNEXIS DOCUMENT SOLUTIONS INC. 1201 HAYS STREET TALLAHASSEE, FL 32301		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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

Filing Fee is \$50.00 Due by May 1, 2005	Make check payable to Florida Department of State
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9. MANAGING MEMBERS / MANAGERS		10. ADDITIONS / CHANGES	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGRM EXTENDICARE HEALTH FACILITIES, INC. 111 W. MICHIGAN ST. MILWAUKEE, WI 53203 <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
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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: Douglas J. Harris 4/27/05 414-928-8000
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #