

**2016 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L08000089128

**Entity Name:** GROVES REHABILITATION CENTER, LLC

**Current Principal Place of Business:**

512 SOUTH 11TH STREET  
LAKE WALES, FL 33853

**Current Mailing Address:**

C/O SPECTOR GADON & ROSEN LLP  
360 CENTRAL AVENUE SUITE 1550  
ST. PETERSBURG, FL 33701 US

**FEI Number:** 26-3411666

**Certificate of Status Desired:** No

**Name and Address of Current Registered Agent:**

C T CORPORATION SYSTEM  
1200 SOUTH PINE ISLAND ROAD  
SUITE 1550  
PLANTATION, FL 33324 US

*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:** \_\_\_\_\_

Electronic Signature of Registered Agent

\_\_\_\_\_ Date

**Authorized Person(s) Detail :**

Title ADMINISTRATIVE MANAGER  
Name JAFFE, HOWARD  
Address TWO BALA PLAZA, SUITE 300  
City-State-Zip: BALA CYNWYD PA 19004

Title MGR  
Name ADMINISTRATOR  
Address 360 CENTRAL AVENUE, SUITE 1550  
City-State-Zip: ST. PETERSBURG FL 33701

Title MGR  
Name DIRECTOR OF NURSING  
Address 360 CENTRAL AVENUE, SUITE 1550  
City-State-Zip: ST. PETERSBURG FL 33701

*I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 605, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.*

**SIGNATURE:** HOWARD JAFFEE

**MANAGER**

**04/29/2016**

\_\_\_\_\_  
Electronic Signature of Signing Authorized Person(s) Detail

\_\_\_\_\_  
Date