

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED


2010 JUL -8 AM 10:46

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

100182635081
06/25/10--01039--005 **277.50

CR2E041 (11/09)

LIMITED LIABILITY COMPANY REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # L04000019445
1. Limited Liability Company's Name
PS OPERATIONS, LLC

2. Principal Office Address - No P.O. Box # 450 Cordova Ave.		3. Mailing Office Address P.O. Box 691	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State DeLeon Springs, FL		City & State DeLeon Springs, FL	
Zip 32130	Country	Zip 32130	Country

4. State/Country of Formation Florida	
5. Date Organized or Qualified To Do Business in Florida March 12, 2004	
6. FEI Number 20-0856441	Applied For Not Applicable
7. CERTIFICATE OF STATUS DESIRED <input type="checkbox"/> \$5.00 Additional Fee required for a Certificate of Status	

8. Name and Address of Current Registered Agent

Name
Patricia A. Schwarze

Street Address (P.O. Box Number is Not Acceptable)
450 Cordova Ave.

Suite, Apt. #, Etc.

City
DeLeon Springs, FL

State
FL

Zip Code
32130

A \$100 reinstatement fee is imposed, except in circumstances which the entity did not receive the prior notices. By checking this box, you are certifying the prior notices were not received and requesting the \$100 reinstatement be waived.

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 608, F.S.

Signature of Registered Agent *Patricia A. Schwarze* Date 6/17/10

REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Managing Members/Managers

Title	Name of Managing Members/Managers	Street Address of Each Managing Member/Manager	City / State / Zip
MGR	Patricia A. Schwarze	450 Cordova Ave.	DeLeon Springs, FL 32130

REINSTATEMENT 09/10

100182635081
07/09/10--01021--005 **100.00

11. E-mail Address: sugarmill@cfl.rr.com (To be used for future annual report notifications)

12. I certify that I am managing member/manager or the receiver or trustee empowered to execute this application as provided for in Chapter 608, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirements of section 608.406, F.S., and that all fees owed by the limited liability company have been paid. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

Signature of Managing Member/Manager *Patricia A. Schwarze* Date 5/10/20 Daytime Phone # 386 985-5644

Typed or printed name of signing Managing Member/Manager Patricia A. Schwarze, Manager