

**2024 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L21000379234

**Entity Name:** MAXICARE THERAPEUTIC OF SOUTHWEST FLORIDA LLC

**Current Principal Place of Business:**

5285 SUMMERLIN RD.  
STE. 101  
FORT MYERS, FL 33919

**Current Mailing Address:**

PO BOX 61022  
FORT MYERS, FL 33906 US

**FEI Number: 87-2313057**

**Certificate of Status Desired: Yes**

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

MASCARINAS, LEMUEL  
5285 SUMMERLIN RD  
STE. 101  
FORT MYERS, FL 33919 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 AMBR  
Name MGOC, LLC  
Address 2152 RANDALL RD.  
City-State-Zip: CARPENTERSVILLE IL 60110

Title AMBR  
Name CRUZ, JOHN MICHAEL D  
Address 4780 CRESTED EAGLE LANE  
City-State-Zip: FORT MYERS FL 33966

Title AMBR  
Name ESTINOS, FREYA ANN  
Address 4780 CRESTED EAGLE LANE  
City-State-Zip: FORT MYERS FL 33966

*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: LEMUEL MASCARINAS**

**OWNER**

**02/08/2024**

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

\_\_\_\_\_  
Date