

FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00

**CORPORATION
ANNUAL REPORT
1995**



FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

**APPROVED
AND
FILED**

95 MAY -1 AM 11:25

**SECRETARY OF STATE
TALLAHASSEE, FLORIDA**

DOCUMENT # H65696 (7)

1. Corporation Name

BAKER/CLAY HEALTH CENTER, INC.

Principal Place of Business

**1100 SHAWNEE RD.
P.O. BOX 840
LIMA OH 45802**

Mailing Address

**1100 SHAWNEE RD.
P.O. BOX 840
LIMA OH 45802**

DO NOT WRITE IN THIS SPACE.

3. Date Incorporated or Qualified

07/09/1985

3a. Date of Last Report

07/25/1994

2. Principal Place of Business

21

Suite, Apt. #, etc.

22

City & State

23

Zip

Country

24

25

2a. Mailing Address

26

Suite, Apt. #, etc.

27

City & State

28

Zip

Country

29

30

4. FEI Number

58-1631943

Applied For

☐ Not Applicable

5. Certificate of Status Desired

☐

**\$8.75 Additional
Fee Required**

6. Election Campaign Financing
Trust Fund Contribution

☐

**\$5.00 May Be
Added to Fees**

8. This corporation has liability for intangible tax under S. 199.032,
Florida Statutes ☐ Yes ☒ No

9. Name and Address of Current Registered Agent

**INGLIS, JOHN S.
201 E. KENNEDY BLVD.
SUITE 1111
TAMPA FL 33602**

10. Name and Address of New Registered Agent

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

Signature (typed or printed name of registered agent and title if applicable)

(NOTE: Registered Agent signature required when resigning)

DATE

12. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY ST ZIP

**DP
BORRA, PIER C.
1100 SHAWNEE ROAD
LIMA OH**

TITLE
NAME
STREET ADDRESS
CITY ST ZIP

**V
BENNETT, STEPHEN T.
1100 SHAWNEE ROAD
LIMA OH**

TITLE
NAME
STREET ADDRESS
CITY ST ZIP

**DT
DUKEMAN, H. BRUCE
1100 SHAWNEE ROAD
LIMA OH**

TITLE
NAME
STREET ADDRESS
CITY ST ZIP

**S
ROUSH, BRAD C.
1100 SHAWNEE RD.
LIMA OH**

TITLE
NAME
STREET ADDRESS
CITY ST ZIP

TITLE
NAME
STREET ADDRESS
CITY ST ZIP

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

11 TITLE
12 NAME
13 STREET ADDRESS
14 CITY ST ZIP

☐ Change ☐ Addition

21 TITLE
22 NAME
23 STREET ADDRESS
24 CITY ST ZIP

**300001513163
-06/14/95--01077--021
****200.00 ****200.00**

☐ Change ☐ Addition

31 TITLE
32 NAME
33 STREET ADDRESS
34 CITY ST ZIP

☐ Change ☐ Addition

41 TITLE
42 NAME
43 STREET ADDRESS
44 CITY ST ZIP

☐ Change ☐ Addition

51 TITLE
52 NAME
53 STREET ADDRESS
54 CITY ST ZIP

☐ Change ☐ Addition

61 TITLE
62 NAME
63 STREET ADDRESS
64 CITY ST ZIP

☐ Change ☐ Addition

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(b), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual report is true and accurate and that my signature shall have the same legal effect as if made under oath, that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 807, Florida Statutes, and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE:

W. Winkulinski *W. Winkulinski*
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4/25/95
Date

(419) 227-2003
Telephone Number

465696

SPECIAL POWER OF ATTORNEY
OF
ARBOR HEALTH CARE COMPANY, A DELAWARE CORPORATION
TO
WILLIAM W. WONDOLOWSKI

The undersigned hereby nominates and appoints William W. Wondolowski as its true and lawful attorney-in-fact to do and perform for and in the name of Arbor Health Care Company the following:

1. Authorized to sign workers' compensation forms, federal and state unemployment forms, any and all tax forms, and any and all employee benefit filings.

The above authorization shall pertain to the attached list of subsidiaries hereto marked as "Exhibit A".

IN FURTHERANCE OF THESE POWERS I give my attorney-in-fact power and authority to do for me and in my name those things which such attorney deems expedient to and necessary to effectuate the intent of this instrument, as fully as I could do personally for myself, reserving unto myself, however, the power to act on my own behalf and also to revoke the powers given in this instrument.

Persons to whom this instrument may be delivered may rely on its being in effect and unrevoked unless I shall have executed a proper instrument of revocation.

IN WITNESS WHEREOF, I have hereunto signed my name this 14th day of September, 1994.

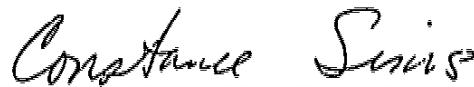


H. Bruce Dukeman, Senior Vice President-Finance

ATTESTATION

Signature acknowledge in the presence of:





HC5696

ACKNOWLEDGMENT

STATE OF OHIO)
)
COUNTY OF ALLEN)

Before me, a Notary Public in and for said County and State, personally appeared the above-named H. Bruce Dukeman, who acknowledged that he did sign the foregoing instrument and that the same is his free and voluntary act and deed.

In testimony whereof, I have hereunto set my hand and official seal at Lima, Ohio, this 14th day of September, 1994.

Constance Sims

Constance Sims - Notary Public

CONSTANCE SIMS
Notary Public, State of Ohio
My Commission Expires 12-26-1997

H65696

EXHIBIT A

ARBOR HEALTH CARE COMPANY SUBSIDIARIES

Marshall Properties
AHCC of North Carolina
Arbors at Toledo
Arbors at Ft. Wayne
Arbors East
Arbors Plus
Woodsvew Nursing Center
Greentree of Florida, Inc.
Greentree Pharmacy, Inc.
Arbors at New Lebanon
Jefferson Health
Calcutta Health Care Company
Baker/Clay Health Care
Highland Centers
Bay Geriatric Pharmacy, Inc.
Home Care Pharmacy