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	Mailing Address
1100 SHAWNEE RD. P.O.BOX 840 LIMA OH 45802	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:
2a. Mailing Address — 26:
Suite, Apt. #, etc. — 22:
Suite, Apt. #, etc. — 27:
City & State — 23:
City & State — 28:
Zip — 24: Country — 25:
Zip — 29: Country — 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 _____ DATE
Signature, typed or printed name of registered agent and title if applicable — NOTE: Registered Agent signature required when reinstating

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	DP	11 TITLE	☐ Change ☐ Addition
NAME	BORRA, PIER C.	12 NAME	
STREET ADDRESS	1100 SHAWNEE ROAD	13 STREET ADDRESS	
CITY ST ZIP	LIMA OH	14 CITY ST ZIP	
TITLE	V	21 TITLE	☐ Change ☐ Addition
NAME	BENNETT, STEPHEN T.	22 NAME	
STREET ADDRESS	1100 SHAWNEE ROAD	23 STREET ADDRESS	
CITY ST ZIP	LIMA OH	24 CITY ST ZIP	
TITLE	DT	31 TITLE	☐ Change ☐ Addition
NAME	DUKEMAN, H. BRUCE	32 NAME	
STREET ADDRESS	1100 SHAWNEE ROAD	33 STREET ADDRESS	
CITY ST ZIP	LIMA OH	34 CITY ST ZIP	
TITLE	S	41 TITLE	☐ Change ☐ Addition
NAME	ROUSH, BRAD C.	42 NAME	
STREET ADDRESS	1100 SHAWNEE RD.	43 STREET ADDRESS	
CITY ST ZIP	LIMA OH	44 CITY ST ZIP	
TITLE		51 TITLE	☐ Change ☐ Addition
NAME		52 NAME	
STREET ADDRESS		53 STREET ADDRESS	
CITY ST ZIP		54 CITY ST ZIP	
TITLE		61 TITLE	☐ Change ☐ Addition
NAME		62 NAME	
STREET ADDRESS		63 STREET ADDRESS	
CITY ST ZIP		64 CITY ST ZIP	

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****200.00 ****200.00

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)(i), 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 607, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE: W. Wm Roberson W Wm Roberson 4/4/95 (419) 227-2001
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone Number

0486481 PN

H65606

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. B. Dukeman

H. Bruce Dukeman, Senior Vice President-Finance

ATTESTATION

Signature acknowledge in the presence of: Cheryl L. Ricker

Constance Sims

HG56016

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
Woodsview 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