PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED
04 JAN -2 PM 1:54
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P02000077637**

1. Corporation Name

WOODS HEALTHCARE GROUP, INC.

Principal Place of Business	Mailing Address
~~10 NORCROSS STREET STE 503~~ ROSEWELL GA 30075 16 Norcross St. Ste 50-B	~~10 NORCROSS STREET STE 503~~ ROSEWELL GA 30075 16 Norcross St Ste 50-B

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

REINSTATEMENT 03

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 07/17/2002

5. FEI Number: 35-2174932 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ $8.75 Additional Fee required for a Certificate of Status

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
D	FLORY, MARY LOU	~~10~~ 16 ~~NORCROSS STREET STE 503~~ 50-B	ROSEWELL GA 30007

500024797365
11/18/03--01037--003 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
MCKIBBEN, R. BRUCE JR 1435 E PIEDMONT DRIVE STE 214 TALLAHASSEE FL 32308	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (7/03)

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S. or 617.0505, F.S.

Signature of Registered Agent: R Bruce McKibben Date: 11-17-03
REGISTERED AGENT MUST SIGN

11. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(i), F.S. 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: SIGNATURE Robert W Hogan 11-17-03 770.993.4000
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

0096846 AT

Woods Healthcare Group, Inc
16 Norcross Street
Suite 50-B
Roswell, GA 30075
Ph: 770-993-4000
Fx: 770-993-9014

October 20, 2003

Division of Corporations
Annual Report/Reinstatement Section
P.O. Box 6327
Tallahassee FL 32314

To Whom It May Concern:

The Notice of Administrative Dissolution or Revocation is the first notice that has been received regarding PalmWood Nursing Center. No prior Uniform Business Report was received. The mailing address was incorrect on the original UBR filed. Please waive the reinstatement fee. Thank you for your assistance.

Sincerely,

Mary Lu Flory
Director
Woods Healthcare Group