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PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED
OCT 14 AM 10:45
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT #
1. Corporation Name
BA HOME HEALTH CARE, INC.
PO3000039412

2. Principal Office Address
5601 Timuquana Rd.
Suite, Apt. #, etc.
Suite C
City & State
Jacksonville, FL
Zip
32210 Country
US

3. Mailing Office Address
City & State
Zip
Country

4. Date Incorporated or Qualified To Do Business in Florida
12/01/03

5. FEI Number
20-0424320

6. CERTIFICATE OF STATUS DESIRED **8.75** An additional fee required for a Certificate of Status

REINSTATEMENT 04 JK

7. Name and Address of Current Registered Agent

Name
Belle B. Almojera, M.D.

Street Address (P.O. Box Number is Not Acceptable)
340 Devonshire Ln.

Suite, Apt. #, Etc.

City
Orange Park, State
FL Zip Code
32073

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of Registered Agent
Belle B. Almojera, M.D. Date
10-11-04

REGISTERED AGENT MUST SIGN

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

Title	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P	Belle B. Almojera, M.D.	340 Devonshire Ln.	Orange Park, FL 32073
VP	Brian M. Almojera	340 Devonshire Ln.	Orange Park, FL 32073

600041875006
10/14/04--01016--004 **158.75

10. 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)(f), 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: **Belle B. Almojera, M.D.** - Belle B. Almojera, M.D. - 10-11-04 (904) 771-5910

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CRS0001 (01/04)

ps 2002

B.A. Home Health Care, Inc.
5601 Timuquana Rd.
Suite C
Jacksonville, FL 32210

10/11/04

Department of State
Division of Corporations
409 East Gaines St.
Tallahassee, FL 32399

Re: Administrative Dissolution of B.A. Home Health Care, Inc. (Document # P03000139412)

To Whom it May Concern:

I am requesting a waiver of the reinstatement fee for B.A. Home Health Care, Inc., because I did not receive notices to file an annual report for 2004. Thank you for your assistance in this matter.

Sincerely,

B. Alnojera
Belle B. Alnojera, M.D.
President