

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

FILED

2007 NOV 14 AM 11:52

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P04000060003

1. Corporation Name

LIVING WELL CARE CENTER  
CORP.

2. Principal Office Address - No P.O. Box #

3779 SW 135 AV

3. Mailing Office Address

SAME

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

MIAMI FL

City & State

Zip

33175

Country

USA

Zip

Country

4. Date Incorporated or Qualified  
To Do Business in Florida

5. FEI Number

260083701

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required  
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

OLGA SIMON

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

3779 SW 135 AVE

Suite, Apt. #, Etc.

City

MIAMI

State

FL

Zip Code

33175

☒ The reinstatement fee is imposed, except in  
circumstances which the entity did not receive  
the prior notices. By checking this box, you  
are certifying the prior notices were not  
received and requesting the reinstatement  
fee be waived.

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

*Olga Simon*

REGISTERED AGENT MUST SIGN

Date

11/13/07

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

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P	MILDRED PERALTA	3779 SW 135 AV	MIAMI FL 33175
VP	OLGA SIMON	3779 SW 135 AV	MIAMI FL 33175
VP	MICHAEL JOHNSON	3779 SW 135 AV	MIAMI FL 33175

000112462460  
11/20/07--01042--006 \*\*150.00

REINSTATEMENT

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 contained in Chapter 119, 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:

*Olga Simon*

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

# LAZARUS

## CORPORATE FILING SERVICE

3320 SW 87<sup>TH</sup> AVENUE

MIAMI, FL 33165 (305) 552-5973

Office Use Only

### CORPORATION NAME(S) & DOCUMENT NUMBER(S), (if known):

1. LIVING WELL CARE CENTER  
(Corporation Name) (Document #)
2. Corp.  
(Corporation Name) (Document #)
3. \_\_\_\_\_  
(Corporation Name) (Document #)
4. \_\_\_\_\_  
(Corporation Name) (Document #)

- ☒ Walk in ☒ Pick up time 2.00 ☐ Certified Copy  
☐ Mail out ☐ Will wait ☐ Photocopy ☐ Certificate of Status

### NEW FILINGS

- ☐ Profit  
☐ Not for Profit  
☐ Limited Liability  
☐ Domestication  
☐ Other

### OTHER FILINGS

- ☐ Annual Report  
☐ Fictitious Name

### AMENDMENTS

- ☐ Amendment  
☐ Resignation of R.A., Officer/Director  
☐ Change of Registered Agent  
☐ Dissolution/Withdrawal  
☐ Merger

### REGISTRATION/QUALIFICATION

- ☐ Foreign  
☐ Limited Partnership  
☒ Reinstatement  
☐ Trademark  
☐ Other

RECEIVED  
TO ACKNOWLEDGE  
SUFFICIENCY OF FILING

2007 NOV 14 AM 11:00

RECEIVED  
DEPARTMENT OF STATE  
DIVISION OF CORPORATIONS

Examiner's Initials