


2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 10, 2006 8:00 am
Secretary of State

03-10-2006 90022 001 *****8.75
03-10-2006 90022 002 ***150.00

DOCUMENT # P05000058082 1. Entity Name HOMESTEAD THERAPEUTIC CARE INC.					
Principal Place of Business 449 NORTH KROME AVE HOMESTEAD, FL 33030				Mailing Address 449 NORTH KROME AVE HOMESTEAD, FL 33030	
2. Principal Place of Business 449 North Krome Ave		3. Mailing Address 449 North Krome Ave			
Suite, Apt. #, etc. 		Suite, Apt. #, etc. 		03022006 Chg-P CR2E034 (11/05)	
City & State Homestead FL		City & State Homestead FL		4. FEI Number 42-1666619	
Zip 33030		Country USA		5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent RUIZ, LAZARO O 449 NORTH KROME AVE HOMESTEAD, FL 33030				7. Name and Address of New Registered Agent Name N/A Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code	
8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.					
SIGNATURE _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE</small>					
FILE NOW!!! FEE IS \$150.00 After May 1, 2006 Fee will be \$550.00			9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees		
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P RUIZ, LAZARO O 449 NORTH KROME AVE HOMESTEAD, FL 33030 <input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
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12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, Florida Statutes. I further certify that the information indicated on this report or supplemental 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 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.					
SIGNATURE: _____ <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>			3/1/06 (305) 247-8767 <small>Date Daytime Phone #</small>		