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2007 FOR PROFIT CORPORATION ANNUAL REPORT

DOCUMENT # P05000122388

1. Entity Name
READY CARE HOME HEALTH, INC.

40055874
→ SEE I.D.# WAS CORRECTED

Principal Place of Business	Mailing Address
4900 SW 74 CT MIAMI, FL 33155	4900 SW 74 CT MIAMI, FL 33155

2. Principal Place of Business - No P.O. Box #	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

03222007 Chg-P CR2E034 (12/06)

4. FEI Number: 20-3554380 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☒ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
HERNANDEZ, ELIZABETH 4900 SW 74TH CT MIAMI, FL 33155	Name 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 ______________________
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

FILE NOW!!! FEE IS $150.00
After May 1, 2007 Fee will be $550.00

9. Election Campaign Financing Trust Fund Contribution. ☐ **$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	PSDT HERNANDEZ, ELIZABETH 4900 SW 74TH CT MIAMI, FL 33155	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition

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: ✓ Elizabeth H. ELIZABETH HERNANDEZ March 22, 2007 (305)
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

460558814 ATTACHMENT P05000122388

Form SS-4 (Rev. December 2004) Department of the Treasury Internal Revenue Service	**Application for Employer Identification Number** (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) ▶ See separate instructions for each line. ▶ Keep a copy for your records.	EIN 20-3554380 OMB No. 1545-0003

1* Legal name of entity (or individual) for whom the EIN is being requested
READY CARE HOME HEALTH INC

2 Trade name of business (if different from name on line 1)	3 Executor, trustee, 'care of' name
4a* Mailing address (room, apt., suite no. and street, or P.O. box) 444 SOUTHWEST 29TH AVE	5a Street address (if different) (Do not enter a P.O. box)
4b* City, state, and ZIP code MIAMI FL 33135 -	5b City, state, and ZIP code

6* County and state where principal business is located
County MIAMI DADE State FL

7a* Name of principal officer, general partner, grantor, owner, or trustor	7b* SSN, ITIN, EIN
ELIZABETH HERNANDEZ RN	593-34-5208

8a* Type of entity (check only one)

- ☐ Sole Proprietor (SSN)
- ☐ Partnership
- ☑ Corporation (enter form number to be filed) ▶ 1120S
- ☐ Personal Service
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☐ Other (specify) ▶
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (SSN)
- ☐ Trust (SSN of grantor)
- ☐ National Guard
- ☐ Farmers' cooperative
- ☐ REMIC
- Group Exemption No. (GEN) ▶
- ☐ State/local government
- ☐ Federal government/military
- ☐ Indian tribal government/enterprises

8b* If a corporation, name the state or foreign country (if applicable) where incorporated	State FL	Foreign country

9* Reason for applying (check only one)

- ☑ Started new business (specify type) ▶ HOME HEALTH CARE
- ☐ Hired employees (Check the box and see line 12)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☐ Banking purpose (specify purpose) ▶
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Created a pension plan (specify type) ▶

10* Date business started or acquired (month, day, year)	11* Closing month of accounting year
SEP 20 2005	DEC

12 First date wages or annuities were paid or will be paid (month, day, year) *Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year)* ▶ NOV 1 2001

13 Highest number of employees expected in the next twelve months *Note: If the applicant does not expect to have any employees during the period, enter "-0-"* ▶	Agriculture	Household	Other
			15

14* Check box that best describes the principal activity of your business

- ☐ Construction
- ☐ Real estate
- ☐ Rental & leasing
- ☐ Manufacturing
- ☐ Transportation & warehousing
- ☐ Finance & insurance
- ☑ Health care & social assistance
- ☐ Accommodation & food service
- ☐ Retail
- ☐ Wholesale-agent/broker
- ☐ Wholesale-other
- ☐ Other (specify)

15* Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided.
HOME HEALTH CARE SERVICES

16a* Has the applicant ever applied for an employer identification number for this or any other business? ☐ Yes ☑ No
Note: If "Yes" please complete lines 16b and 16c

16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above.
Legal name ▶
Trade name ▶

16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (month, day, year)	City and state where filed	Previous EIN

Third Party Designee

Complete section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form

Designee's name	Designee's telephone number (include area code)
CORPDIRECT AGENTS INC CINDY HICKS	(800) 388 - 2123
Address and ZIP code	Designee's fax number (include area code)
515 EAST PARK AVENUE TALLAHASSEE FL 32301 -	(850) 224 - 1640

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.	Applicant's telephone number (include area code)
Name and title (type or print clearly) ▶ ELIZABETH HERNANDEZ	(305) 444 - 5565
Signature ▶ Not Required Date ▶ September 30, 2005 GMT	Applicant's fax number (include area code) (305) 444 - 8588