2007 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Jun 19, 2007 8:00 am
Secretary of State

05-01-2007 90024 025 ***150.00

DOCUMENT # P06000011876

1. Entity Name
HEALTHY HEALING ARTS CENTRE, INC.

66019447

Principal Place of Business	Mailing Address
P.O. BOX 325 LEHIGH ACRES FL 33970 US	P.O. BOX 325 LEHIGH ACRES FL 33970 US

1st MOORE CR2E034 (10/06)

2. Principal Place of Business - No P.O. Box #	3. Mailing Address
5 Randy Lane	
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: Lehigh Fla.	City & State
Zip: 33972 Country: USA.	Zip Country

4. FEI Number: 20-4190168 — Applied For / Not Applicable

5. Certificate of Status Desired ☐ $8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

CHOUINARD, JAMES A CPA
9541 CYPRESS LAKE DRIVE SUITE 5
FORT MYERS FL 33919

Del
Holly Sansone
as listed below

7. Name and Address of New Registered Agent

Name: HOLLY SANSONE
Street Address (P.O. Box Number is Not Acceptable): 5 RANDY LANE
PO BOX 325
City: LEHIGH ACRES FL Zip Code: 33970

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: Holly Sansone — June 1, 07
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
Make Check Payable to Florida Department of State

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	P SANSONE, PETER F P.O. BOX 325 LEHIGH ACRES FL 33970	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	VP SANSONE, HOLLY L P.O. BOX 325 FORT MYERS FL 33970	☐ 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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12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 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: Peter Sansone MD Peter Sansone MD. (239) 369-5617
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

chk# 1219