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PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

SECRETARY OF STATE
DIVISION OF CORPORATIONS

2021 DEC 31 PM 12:07

600378988396

CP2E081 (11/10)

DOCUMENT # F05000006863

1. Corporation Name

PROMISE HOSPITAL OF DADE, INC.

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
c/o Advisory Trust Group, LLC 10645 N. Oracle Road	c/o Advisory Trust Group, LLC 10645 N. Oracle Road
Suite, Apt. #, etc.: Suite 1211-371	Suite, Apt. #, etc.: Suite 1211-371
City & State: Oro Valley, AZ	City & State: Oro Valley, AZ
Zip: 85737 Country: USA	Zip: 85737 Country: USA

4. Date Incorporated or Qualified To Do Business in Florida: Delaware

5. FEI Number: 02-0747837 ☐ 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: CORPORATION SERVICE COMPANY

Street Address (P.O. Box Number is Not Acceptable): 1201 HAYS STREET

Suite, Apt. #, Etc.:

City: TALLAHASSEE State: FL Zip Code: 32301

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: Eylina Baker Assistant Vice President — Date: 01/03/2022

REGISTERED AGENT MUST SIGN

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
Debtor Rep.	Bob Michaelson	c/o Advisory Trust Group, LLC 10645 N. Oracle Road, Suite 1211-371	Oro Valley, AZ 85737
			DEC 31 2021
	REINSTATEMENT		R. HUNT

10. **E-mail Address:** bob michaelson@advisorytgllc.com

(To be used for future annual report notification)

11. 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., and that all fees owed by the corporation have been paid. I further certify, the information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.

SIGNATURE: Bob Michaelson — Bob Michaelson — 12-22-2021

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

CORPORATION SERVICE COMPANY
1201 Hays Street
Tallhassee, FL 32301
Phone: 850-558-1500

ACCOUNT NO. : I20000000195

REFERENCE : 354896 4814048

AUTHORIZATION :

COST LIMIT : $750.00

ORDER DATE : December 29, 2021

ORDER TIME : 1:56 PM

ORDER NO. : 354896-165

CUSTOMER NO: 4814048

REINSTATEMENT

NAME: PROMISE HOSPITAL OF DADE, INC.

2022 JAN -4 PM 4:21

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

_____ CERTIFIED COPY
XX PLAIN STAMPED COPY
_____ CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Eyliena Baker

DEC 31 2021
R. HUNT

EXAMINER'S INITIALS _____