PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
08 MAR -3 PM 12:52
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # H74435

1. Corporation Name

SOUTH MIAMI HEALTH ENTERPRISES, INC.

REINSTATEMENT 06-08

CR2E081 (12/07)

2. Principal Office Address - No P.O. Box #		**3.** Mailing Office Address	
Suite, Apt. #, etc. 6855 RED ROAD # 600		Suite, Apt. #, etc. 6855 RED ROAD # 600	
City & State CORAL GABLES, FLORIDA		City & State CORAL GABLES, FLORIDA	
Zip 33143	Country USA	Zip 33143	Country USA

4. Date Incorporated or Qualified To Do Business in Florida 09/05/1985

5. FEI Number 592623930 ☐ 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
DAVID R. FRIEDMAN

Street Address (P.O. Box Number is Not Acceptable)
6855 RED ROAD, # 600

Suite, Apt. #, Etc.

City: CORAL GABLES | State: FL | Zip Code: 33143

☐ 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 _____ Date 02/15/2008
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
PD	BRIAN E. KEELEY	6855 RED ROAD # 600	CORAL GABLES, FL 33143
STD	RALPH E. LAWSON	6855 RED ROAD # 600	CORAL GABLES, FL 33143
			600119252236

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: _____ BRIAN E. KEELEY 02/15/2008 786-662-7401
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

468369

CORPORATION SERVICE COMPANY®

ACCOUNT NO. : 072100000032

REFERENCE : 468369 4312787

AUTHORIZATION :

COST LIMIT : $1058.75

ORDER DATE : March 3, 2008

ORDER TIME : 9:58 AM

ORDER NO. : 468369-005

CUSTOMER NO: 4312787

DOMESTIC FILINGS

RECEIVED
DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
2008 MAR -3 AM 10:42

FILED
TO ACKNOWLEDGE
SUFFICIENCY OF FILING

NAME: SOUTH MIAMI HEALTH ENTERPRISES, INC.

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

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

CONTACT PERSON: Carina L. Dunlap - Ext# 2951

EXAMINER'S INITIALS