1052

APPROVED AND FILED

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

14 NOV 19 PM 4:43

SECRETARY OF STATE
TALLAHASSEE FLORIDA

DOCUMENT # L13000164902

1. Limited Liability Company's Name

MIAMI QUALITY HEALTHCARE, LLC

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
8000 Southwest 117th Avenue	8000 Southwest 117th Avenue
Suite, Apt. #, etc.	Suite, Apt. #, etc.
Suite 201	Suite 201
City & State	City & State
Miami, FL	Miami, FL
Zip / Country	Zip / Country
33183 / United States	33183 / United States

4. State/Country of Formation: Florida

5. Date Organized or Qualified To Do Business in Florida: 11/25/2013

6. FEI Number: 46-4234658 ☐ Applied For ☐ Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☐ $5.00 Additional Fee required for a Certificate of Status

8. 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

600266795676

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 605, F.S.

Signature of Registered Agent: [signature] Courtney Williams Asst. Vice President Date: 11/19/14

REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Authorized Representatives/Managers

Titles	Name of Authorized Representatives/ Managers	Street Address of Each Authorized Representative/ Manager	City / State / Zip
AMBR	Carlos Vazquez	8000 Southwest 117th Avenue,Suite 201	Miami, FL 33183
AMBR	Dario Pancorbo	8000 SW 117 Ave, Suite 201	Miami, FL 33183

11. E-mail Address: chm@chofmiami.com
(To be used for future annual report notifications)

12. I certify that I am an authorized representative/manager or the receiver or trustee empowered to execute this application as provided for in Chapter 605, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirements of section 605.0012, F.S., and that all fees owed by the limited liability company have been paid. 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 to the Department of State constitutes a third degree felony as provided in s. 817.155, F.S.

Signature of Authorized Representative/Manager: [signature] Date: 11/05/2014 Daytime Phone #: 3052790152

Typed or printed name of signing Authorized Representative/Manager: Carlos Vazquez, Member

CORPORATION SERVICE COMPANY

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ACCOUNT NO. : I20000000195

REFERENCE : 346261 8018778

AUTHORIZATION :

COST LIMIT : $ 238.75

ORDER DATE : October 21, 2014

ORDER TIME : 3:22 PM

ORDER NO. : 346261-010

CUSTOMER NO: 8018778

DOMESTIC FILINGS

NAME: MIAMI QUALITY HEALTHCARE, LLC

FILED
2014 NOV 19 AM 11:22
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

XX ___ REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

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

CONTACT PERSON: Courtney Williams - Ext# 62935

EXAMINER'S INITIALS _____