
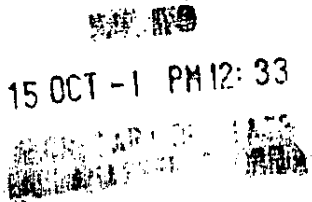
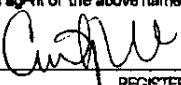
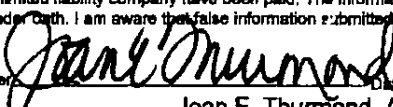


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

LIMITED LIABILITY COMPANY REINSTATEMENT		 FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS		<div style="text-align: right;">  </div>	
DOCUMENT # M10000000754 1. Limited Liability Company's Name Life Care Physician Services, LLC					
2. Principal Office Address - No P.O. Box # 3570 Keith Street, NW Suite, Apt. #, etc.		3. Mailing Office Address Suite, Apt. #, etc.		CR2E041 (1/14) 4. State/Country of Formation TN 5. Date Organized or Qualified To Do Business in Florida 2/17/2010 6. FEI Number 27-1882094 <div style="float: right;"> <input type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable </div>	
City & State Cleveland, TN Zip 37312 Country Bradley		City & State Zip Country		7. CERTIFICATE OF STATUS DESIRED <input checked="" type="checkbox"/> \$2,400 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) Suite, 1201 Hays Street Apt. #, Etc. City Tallahassee State FL Zip Code 32301				200277647272	
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  Courtney Williams <div style="display: flex; justify-content: space-between;"> REGISTERED AGENT MUST SIGN Asst. Vice President Date 10.01.15 </div>					
10. Names and Street Addresses of Authorized Representatives/Managers					
Title	Name of Authorized Representative/Manager	Street Address of Each Authorized Representative/Manager	City / State / Zip		
AR	Forrest L. Preston	3570 Keith Street, NW	Cleveland, TN 37312		
AR	JoAnna Crooks	3570 Keith Street, NW	Cleveland, TN 37312		
AR	Cindy S. Cross	3570 Keith Street, NW	Cleveland, TN 37312		
AR	Joan E. Thurmond	3570 Keith Street, NW	Cleveland, TN 37312		
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="font-size: 2em; font-weight: bold;">REINSTATEMENT</div> <div style="text-align: right;"> OCT 01 2015 R. HUNT </div> </div>					
11. E-mail Address: joan_thurmond@lcca.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 requirement 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 in a document to the Department of State constitutes a third degree felony as provided for in s. 817.155, F.S.					
Signature of authorized representative/member  Joan E. Thurmond Date 9/30/15 Day/night Phone # 423-473-5868 Typed or printed name of signing authorized representative/member Joan E. Thurmond, Assistant Secretary					

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

ACCOUNT NO. : I20000000195

REFERENCE : 812815 7864759

AUTHORIZATION :

COST LIMIT : \$ 238.75

ORDER DATE : September 30, 2015

ORDER TIME : 5:21 PM

ORDER NO. : 812815-005

CUSTOMER NO: 7864759

REINSTATEMENT

NAME: LIFE CARE PHYSICIAN SERVICES,
LLC

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

 CERTIFIED COPY
XX PLAIN STAMPED COPY
 CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Courtney Williams

OCT 01 2015

EXAMINER'S INITIALS R. HUNT

RECEIVED
DEPARTMENT OF
15 OCT - 1 AM 10:50
TO AGENT FOR
SUFFICIENCY OF FILING