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PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**LIMITED LIABILITY COMPANY REINSTATEMENT**

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

2021 DEC 31 PM 12:07

DOCUMENT # M13000006980

800378983948

CR2E041 (1/14)

1. Limited Liability Company's Name
SUCCESS HEALTHCARE, LLC

| 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, Apt. #, etc. | |
| Suite 1211-371 | | Suite 1211-371 | |
| City & State | | City & State | |
| Oro Valley, AZ | | Oro Valley, AZ | |
| Zip | Country | Zip | Country |
| 85737 | USA | 85737 | USA |

4. State/Country of Formation
Florida

5. Date Organized or Qualified To Do Business in Florida
11/04/2013

6. FEI Number
20-1872766
☐ 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 | State | Zip Code |
|---|---|---|
| TALLAHASSEE | FL | 32301 |

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 Eylima Baker Assistant Vice President Date 01/03/2021

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

11. E-mail Address: bob.michaelson@advisorytgllc.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 608, 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 Bob Michaelson Date 12-22-2021 Daytime Phone #

Typed or printed name of signing Authorized Representative/Manager Bob Michaelson

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

ACCOUNT NO. : I20000000195

REFERENCE : 354896 4814048

AUTHORIZATION :

COST LIMIT : $ 500.00

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ORDER DATE : December 29, 2021

ORDER TIME : 1:48 PM

ORDER NO. : 354896-145

CUSTOMER NO: 4814048

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REINSTATEMENT

NAME: SUCCESS HEALTHCARE, LLC

2021 JAN -4 PM 4:27

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 _____