PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1/2

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
06 APR 19 PM 1:42
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P03000060847

1. Corporation Name
ALLIED HEALTHCARE FACILITIES INC.

2. Principal Office Address	3. Mailing Office Address
1814 NE. Miami Gardens Dr.	
Suite, Apt. #, etc.: #601	Suite, Apt. #, etc.
City & State: N. Miami, FL.	City & State
Zip: 33179 Country: Dade	Zip Country

CR2E081 (12/05)

REINSTATEMENT 04-06

4. Date Incorporated or Qualified To Do Business in Florida

5. FEI Number: 65-0265-241 ☐ 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: JAY LIEBMAN

Street Address (P.O. Box Number is Not Acceptable): 1814 NE. Miami Gardens Dr.

200072818582
04/28/06--01052--002 **458.75

Suite, Apt. #, Etc.: #601

City: N. Miami State: FL Zip Code: 33179

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: Jay Liebman director
REGISTERED AGENT MUST SIGN

Date: 4/19/06

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
President	JAY LIEBMAN	1814 NE. Miami Gardens Dr. #601	N. Miami, FL. 33179

Effective APR 10 2006

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: JAY LIEBMAN / Jay Liebman director 4/19/06
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

2/2

From: Allied Health Care Facilities, Inc.
1814 NE MIAMI GARDENS DR. #601
N. Miami, FL. 33179

4/19/06

To Whom It May Concern,

This letter is to inform you that we did not receive the 2004-2005 Annual Report.

Sincerely yours,

[signature] Director