PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

05 APR -1 AM 9:24

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # L00000015510

1. Limited Liability Company's Name
Northwood Healthcare, LLC

2. Principal Office Address	**3.** Mailing Office Address
2800 Broadway	129 Newbridge Road
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: West Palm Beach, Florida	City & State: Hicksville, New York
Zip: 33407 Country: USA	Zip: 11801 Country: USA

4. State/Country of Formation: Florida/USA

5. Date Organized or Qualified To Do Business in Florida: 12/14/2000

6. FEI Number: 65-1079099 ☐ 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: Guy Rabideau

Street Address (P.O. Box Number is Not Acceptable): 400 Royal Palm Way

Suite, Apt. #, Etc.: Suite 410

City: Palm Beach State: FL Zip Code: 33480

REINSTATEMENT 04-05

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 608, F.S.

Signature of Registered Agent: _____ Date: 3/14/2005

REGISTERED AGENT MUST SIGN

CR2E041 (10/02)

10. Names and Street Addresses of Managing Members/Managers

Titles	Name of Managing Members/Managers	Street Address of Each Managing Member/Manager	City / State / Zip
MGMR	Peter Fischer	129 Newbridge Road	Hicksville, NY 11801
			400005067067 04/13/05--01059--013 **155.00
			400005067067 04/13/05--01059--014 **50.00

11. I certify that I am managing member/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 608.406, 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.

Signature of Managing Member/Manager: _____ Date: 3/6/05 Daytime Phone #: 561.655.6221

Typed or printed name of signing Managing Member/Manager: Peter Fischer