
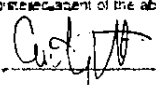
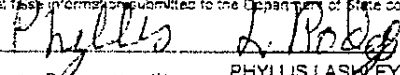


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

| LIMITED LIABILITY COMPANY REINSTATEMENT  | | FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS | | FILED 14 OCT 21 PM 1:31 SECRETARY OF STATE TALLAHASSEE, FLORIDA | |
|---|---|--|---------------------------------|---|--------------------------|
| DOCUMENT # L23000024458 1. Limited Liability Company's Name ST. PHILOMENA ASSISTED LIVING FACILITIES, LLC | | | | | |
| 2. Principal Office Address - No P.O. Box # 3943 Eldridge Ave. | | 3. Mailing Office Address 3943 Eldridge Ave | | 4. State/Country of Formation Florida | |
| Same Apt. # etc. | | State, Apt. # etc. | | 5. Date Organized or Qualified To Do Business in Florida 02/19/2013 | |
| City & State Orange Park, FL | | City & State Orange Park, FL | | 6. FEI Number <input type="checkbox"/> Applied For <input checked="" type="checkbox"/> Not Applicable | |
| Zip 32073 | Country United States | Zip 32073 | Country United States | 7. CERTIFICATE OF STATUS DESIRED <input checked="" type="checkbox"/> \$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. | | | | 900265654829 | |
| City Tallahassee | | | | State FL | Zip Code 32301 |
| 9. I, being appointed, authorized agent of the above named limited liability company, do hereby certify that the information furnished herein complies with the provisions of Chapter 605, F.S. Signature of Registered Agent  Courtney Williams Asst. Vice President Date 10-21-14 | | | | | |
| 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 | Phyllis Lashley Rodgers | 3943 ELDRIDGE AVE. | ORANGE PARK, FL 32073 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 11. E-mail Address STPHILOMENA73@GMAIL.COM <small>(To be used for future annual report notifications)</small> | | | | | |
| 12. I certify that I am an authorized representative/manager of 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. 817.165, F.S. | | | | | |
| Signature of Authorized Representative/Manager  | | Date 10-19-14 | | Daytime Phone # 904-470-9965 | |
| Typed or printed name of signing Authorized Representative/Manager PHYLLIS LASHLEY RODGERS | | | | | |



CORPORATION SERVICE COMPANY

2 of 2 page

FILED

14 OCT 21 PM 1:31

ACCOUNT NO. : I2000000019
 REFERENCE : 338066
 AUTHORIZATION : *[Signature]*
 COST LIMIT : \$ 243,75

SECRETARY OF STATE
 TALLAHASSEE, FLORIDA
 7924529

ORDER DATE : October 15, 2014
 ORDER TIME : 8:54 AM
 ORDER NO. : 338066-010
 CUSTOMER NO: 7924529

DOMESTIC FILINGS

NAME: ST. PHILOMENA ASSISTED LIVING FACILITIES, LLC

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

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

CONTACT PERSON: Courtney Williams - Ext# 62935

EXAMINER'S INITIALS _____

RECEIVED
 DEPARTMENT OF STATE
 14 OCT 21 AM 11:04