

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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LIMITED LIABILITY COMPANY REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Katherine Harris
 Secretary of State
 DIVISION OF CORPORATIONS

FILED

00 DEC 18 AM 11:40

SECRETARY OF STATE
 TALLAHASSEE, FLORIDA

REINSTATEMENT *2000*

DOCUMENT # *L99-8207*
 1. Limited Liability Company's Name
LITTLE FOREST MEDICAL CENTER LLC

2. Principal Office Address
950 CALLEON DR
 Suite, Apt. #, etc.
 City & State
NAPLES, Fla.
 Zip Country
34102 U.S.A.

3. Mailing Office Address
 Suite, Apt. #, etc.
 City & State
 Zip Country

4. State/Country of Formation
 5. Date Organized or Qualified To Do Business in Florida
 6. FEI Number 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
PATRICIA C. POTTS 900003510939-7
 Street Address (P.O. Box Number is Not Acceptable)
950 CALLEON DR. -12/21/00--01093--013
 Suite, Apt. #, Etc. *****150.00 ****150.00*
 City
NAPLES State Zip Code
FL 34102

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 *Patricia C. Potts* Date *10-19-2000*
 REGISTERED AGENT MUST SIGN

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
<i>MGR</i>	<i>SHARI ALURK</i>	<i>21498 MAGNOLIA HILLS DR.</i>	<i>MAGNOLIA, TX. 77354</i>
<i>MGR</i>	<i>PATRICIA C. POTTS</i>	<i>950 CALLEON DR.</i>	<i>NAPLES, Fla. 34102</i>
<i>MGR</i>	<i>GREGORY J. GIBSON</i>		

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 *Patricia C. Potts* Date *10-19-2000* Daytime Phone # *941-261-6919*
 Typed or printed name of signing Managing Member/Manager *PATRICIA C. POTTS*

CR2E041 (9/99)