PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED
13 JAN 30 PM 2:49
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # M11000002559

1. Limited Liability Company s Name

Novia CareClinics, LLC

CR2E041 (1/11)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
429 N. Pennsylvania St.	429 N. Pennsylvania St.
Suite, Apt. #, etc: 400	Suite, Apt. #, etc: 400
City & State: Indianapolis, IN	City & State: Indianapolis, IN
Zip: 46204 Country:	Zip: 46204 Country:

4. State/Country of Formation: Indiana

5. Date Organized or Qualified To Do Business in Florida: June 22, 2006

6. FEI Number: 20-5094727 ☐ 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: CT Corporation System

Street Address (P.O. Box Number is Not Acceptable): 1200 S. Pine Island Road

Suite, Apt. #, Etc.:

City: Plantation State: FL Zip Code: 33324

E-mail Address:
900243675279
01/15/13--01015--004 **243.75

jbridge@psrb.com

(To be used for future annual report notices)

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: James M. Halpin Date: 01/07/2013

REGISTERED AGENT (PRINTED): Assistant Secretary

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
MGRM	John B. Bridge	1346 N. Delaware St.	46202
			900243675279 01/30/13--01002--023 **138.75

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. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.

Signature of Managing Member/Manager: John B. Bridge Date: 1/9/13 Daytime Phone #: (317) 637-0700

Typed or printed name of signing Managing Member/Manager:

1/30