PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETINGTHIS FORM

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # M15000008043

1. Limited Liability Company's Name
SPROUT HEALTH LLC

500291993585

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box #		3. Mailing Office Address	
3 Corbett Way		3 Corbett Way	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Eatontown, NJ		Eatontown, NJ	
Zip	Country	Zip	Country
07724	USA	07724	USA

4. State/Country of Formation
Delaware

5. Date Organized or Qualified To Do Business in Florida 10/08/2015

6. FEI Number
46-3813854
☐ 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
Corporation Service Company

Street Address (P.O. Box Number is Not Acceptable) Suite,
1201 Hays Street

Apt #, Etc.

City	State	Zip Code
Tallahassee	FL	32301

16 NOV -4 PM 12:53

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 605, F.S.

Signature of Registered Agent M. Zender — Melissa Zender — Date 11/4/16
REGISTERED AGENT MUST SIGN
Asst. Vice President

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
CEO	Arel Meister-Aldama	3 Corbett Way	Eatontown, NJ 07724
			S. HAWKES

11. E-mail Address: jeanne@sprouthealthgroup.com
(To be used for future annual report notifications)

NOV -4 A.M.

12. I certify that I am an authorized representative/ manager or 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 requirement 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 in a document to the Department of State constitutes a third degree felony as provided for in s. 817.155, F.S.

Signature of authorized representative/member _____ Date 11/3/2016 Daytime Phone # 888-687-6977

Typed or printed name of signing authorized representative/member Arel Meister-Aldama

CORPORATION SERVICE COMPANY
1201 Hays Street
Tallhassee, FL 32301
Phone: 850-558-1500

ACCOUNT NO. : I20000000195

REFERENCE : 349825 8052712

AUTHORIZATION

COST LIMIT : $ 238.75

ORDER DATE : October 28, 2016

ORDER TIME : 10:28 AM

ORDER NO. : 349825-035

CUSTOMER NO: 8052712

REINSTATEMENT

NAME: SPROUT HEALTH, LLC

16 NOV -4 AM 10:48
RECEIVED
FLORIDA DEPARTMENT OF STATE

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

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

CONTACT PERSON: Melissa Zender

EXAMINER'S INITIALS _____