
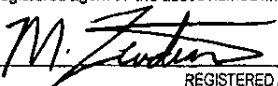
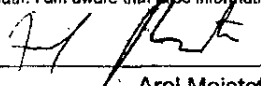


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

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			
2. Principal Office Address - No P.O. Box # 3 Corbett Way Suite, Apt. #, etc.		3. Mailing Office Address 3 Corbett Way Suite, Apt. #, etc.	
City & State Eatontown, NJ		City & State Eatontown, NJ	
Zip 07724	Country USA	Zip 07724	Country 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			<input type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable
7. CERTIFICATE OF STATUS DESIRED <input 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) Suite, 1201 Hays Street Apt #, Etc. City Tallahassee		State FL	
Zip Code 32301		16 NOV - 4 PM 12:53 SECRETARY OF STATE DIVISION OF CORPORATIONS	
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  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@sprouthhealthgroup.com 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
Tallahassee, FL 32301
Phone: 850-558-1500

ACCOUNT NO. : I20000000195

REFERENCE : 349825 8052712

AUTHORIZATION

[Signature]

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

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 _____

RECEIVED
DEPARTMENT OF
16 NOV -4 AM 10:48