

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS

17 FEB 16 PM 12:54

**LIMITED LIABILITY  
COMPANY  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

**DOCUMENT # M1500008397**

1. Limited Liability Company's Name

North Port Health Investors, LLC

400295635214

CR2E041 (1/14)

4. State/Country of Formation  
**Delaware**

5. Date Organized or Qualified  
To Do Business in Florida **October 20, 2015**

6. FBI Number ☒ Applied For  
☐ Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☐ \$5.00 Additional Fee required  
for a certificate of status

2. Principal Office Address - No P.O. Box #  
**1300 Spring Street**

Suite, Apt. #, etc.  
**Suite 205**

City & State  
**Silver Spring, MD**

Zip Country  
**20910 USA**

3. Mailing Office Address  
**1300 Spring Street**

Suite, Apt. #, etc.  
**Suite 205**

City & State  
**Silver Spring, MD**

Zip Country  
**20910 USA**

**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**

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*  
REGISTERED AGENT MUST SIGN

**Melissa Zender**  
**Asst. Vice President**

Date **2/16/17**

**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
Member	Daniel Castleberry	1300 Spring Street, Suite 205	Silver Spring, MD 20910

11. E-mail Address: **dcastleberry@meridiansenior.com**

(To be used for future annual report notifications)

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

*Sheldon Bender*

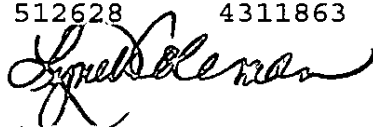
Date **2/13/17**

Daytime Phone # **215-569-5406**

Typed or printed name of signing authorized representative/member **Sheldon Bender**

FEB 16 2017

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

ACCOUNT NO. : I20000000195  
REFERENCE : 512628 4311863  
AUTHORIZATION :   
COST LIMIT : \$ 377.50

ORDER DATE : February 15, 2017  
ORDER TIME : 9:45 AM  
ORDER NO. : 512628-005  
CUSTOMER NO: 4311863

REINSTATEMENT

NAME: NORTH PORT HEALTH INVESTORS,  
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 \_\_\_\_\_