

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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LIMITED LIABILITY COMPANY REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

2021 APR -7 PM 12:29

DOCUMENT # M18000010736

1. Limited Liability Company's Name
Harmony Health Propco, LLC

LLP210001211

100363918021

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box # 2901 Stirling Road		3. Mailing Office Address 2901 Stirling Road	
Suite, Apt. # etc Suite 200		Suite, Apt. #, etc Suite 200	
City & State Ft. Lauderdale, FL		City & State Ft. Lauderdale, FL	
Zip 33312	Country US	Zip 33312	Country US

4. State/Country of Formation Delaware	
5. Date Organized or Qualified To Do Business in Florida 11/30/2018	
6. FEI Number 83-2528012	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
Cogency Global Inc.

Street Address (P.O. Box Number is Not Acceptable) Suite
115 N Calhoun St

Apt. #, Etc
Suite 4

City Tallahassee	State FL	Zip Code 32301
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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 Sheila Carroll, Asst. Secy. Date 3/23/2021

REGISTERED AGENT MUST SIGN

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
MGR	Bent Philipson	22 Pleasant Ridge Road	Spring Valley, NY 10977

11. E-mail Address _____
(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 /s/ Bent Philipson Date 3/23/2021 Daytime Phone # _____

Typed or printed name of signing authorized representative/member Bent Philipson, Authorized Person

T MOORE



COGENCYGLOBAL

115 N CALHOUN ST., STE. 4
TALLAHASSEE, FL 32301
866.625.0838
COGENCYGLOBAL.COM

PA. 20/21

Account#: 120000000088

Date: April 07, 2021

Name: KEN HOWELL

Reference #: 1351989

Entity Name: HARMONY HEALTH PROPCO LLC

Articles of Incorporation/Authorization to Transact Business

Amendment

Change of Agent

Reinstatement

Conversion

Merger

Dissolution/Withdrawal

Fictitious Name

Other _____

**ISSUES? CALL
KEN:
518-213-0738**

Authorized Amount: **\$238.75**

Signature: *Ken Howell*