

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM **FILED**

**LIMITED LIABILITY  
COMPANY  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

2023 OCT 12 PM 12:26

SECRETARY OF STATE  
TALLAHASSEE, FL 32399

800417288768

DOCUMENT # M20000006439

1. Limited Liability Company's Name  
Rhythm Healthcare, LLC

2. Principal Office Address - No P.O. Box #  
3200 Tyrone Boulevard N

Suite, Apt. #, etc.  
Suite C

City & State  
St. Petersburg, FL

Zip Country  
33710 Pinellas

3. Mailing Office Address  
3200 Tyrone Boulevard N

Suite, Apt. #, etc.  
Suite C

City & State  
St. Petersburg, FL

Zip Country  
33710 US

CR2E041 (1/14)

4. State/Country of Formation  
Delaware, US

5. Date Organized or Qualified  
To Do Business in Florida 7/27/2020

6. FEI Number Applied For  
85-1558216 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) Suite,  
1200 South Pine Island Road

Apt. #, Etc.

City State Zip Code  
Plantation FL 33324

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 Madonna Cuddihy Madonna Cuddihy, Assistant Secretary Date 10/6/2023  
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
M	Douglas Francis	1616 Stewart Lane	Syosset, NY 11791

M. MOON  
OCT 18 2023

11. E-mail Address GColbert@Rhythmhc.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 Gary Colbert Date 10/6/2023 Daytime Phone # 941-323-9555  
Typed or printed name of signing authorized representative/member Gary Colbert, Authorized Representative

**CT CORP**  
**(850) 656- 4724**  
**3558 lakesore Drive**  
**Tallahassee, FL 32312**

**Date:** 10/12/2023

Acc#I20160000072

*en: c 12/11*

Name:	Rhythm Healthcare LLC
Document #:	
Order #:	15170284

Certified Copy of Arts & Amend:	<input type="checkbox"/>	<div>RECEIVED 2023 OCT 12 AM 11:06 DIRECTOR'S OFFICE DIVISION OF CORPORATIONS TALLAHASSEE, FLORIDA</div>	
Plain Copy:	<input type="checkbox"/>		
Certificate of Good Standing:	<input type="checkbox"/>		
Certified Copy of	<input type="checkbox"/>		
Apostille/Notarial Certification:	<input type="checkbox"/>	Country of Destination:	
		Number of Certs:	

Filing: <input checked="" type="checkbox"/>	Certified: <input checked="" type="checkbox"/>	Email Address for Annual Report Notifications: <div></div>
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	COGS: <input type="checkbox"/>	

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Amount: \$ **100.00**

Thank you!