

L14000109754

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

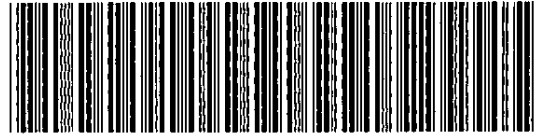
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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TO ASSOCIATE  
SUFFICIENCY OF FILING

2014 JUL 10 AM 10:46

TO ASSOCIATE  
SUFFICIENCY OF FILING

14 JUL 10 PM 4:45



CORPORATION SERVICE COMPANY

ACCOUNT NO. : I20000000195

REFERENCE : 210163 7509084

AUTHORIZATION :

COST LIMIT : \$125.00

ORDER DATE : July 10, 2014

ORDER TIME : 8:45 AM

ORDER NO. : 210163-040

CUSTOMER NO: 7509084

DOMESTIC FILING

NAME: VESTAL INPATIENT SERVICES,  
LLC

EFFECTIVE DATE:

       ARTICLES OF INCORPORATION  
       CERTIFICATE OF LIMITED PARTNERSHIP  
XX ARTICLES OF ORGANIZATION

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

       CERTIFIED COPY  
XX PLAIN STAMPED COPY  
       CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Courtney Williams - EXT. 62925

EXAMINER'S INITIALS: \_\_\_\_\_

**COVER LETTER**

**TO: Registration Section  
Division of Corporations**

**SUBJECT: Vestal Inpatient Services, LLC**  
Name of Limited Liability Company

The enclosed Articles of Organization and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Robyn Ratton  
Name of Person

Envision HealthCare attn: Legal Department  
Firm/Company

6200 S. Syracuse Way, Suite 200  
Address

Greenwood Village, CO 80111  
City/State and Zip Code

lynneliko@evhc.net  
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Robyn Ratton at ( 303 ) 495-1217  
Name of Person Area Code Daytime Telephone Number

Enclosed is a check for the following amount:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> \$125.00 Filing Fee | <input type="checkbox"/> \$130.00 Filing Fee &<br>Certificate of Status | <input type="checkbox"/> \$155.00 Filing Fee &<br>Certified Copy<br>(additional copy is enclosed) | <input type="checkbox"/> \$160.00 Filing Fee,<br>Certificate of Status &<br>Certified Copy<br>(additional copy is enclosed) |
|--|---|---|---|

**Mailing Address**  
Registration Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

**Street/Courier Address**  
Registration Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

**ARTICLE I - Name:**

The name of the Limited Liability Company is:

Vestal Inpatient Services, LLC

(Must end with the words "Limited Liability Company, "L.L.C.," or "LLC.")

**ARTICLE II - Address:**

The mailing address and street address of the principal office of the Limited Liability Company is:

**Principal Office Address:**

**Mailing Address:**

6200 S. Syracuse Way, Suite 200  
Greenwood Village, CO 80111

6200 S. Syracuse Way, Ste. 200  
Greenwood Village, CO 80111  
attn: Legal Department

**ARTICLE III - Registered Agent, Registered Office, & Registered Agent's Signature:**

(The Limited Liability Company cannot serve as its own Registered Agent. You must designate an individual or another business entity with an active Florida registration.)

The name and the Florida street address of the registered agent are:

Corporation Service Company

Name

1201 Hays Street

Florida street address (P.O. Box **NOT** acceptable)

Tallahassee

FL

City

Zip

*Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate, I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relating to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent as provided for in Chapter 605, F.S..*

Emily Gray Asst VP  
Registered Agent's Signature (REQUIRED)

(CONTINUED)

**ARTICLE IV-**

The name and address of each person authorized to manage and control the Limited Liability Company:

**Title:**

"AMBR" = Authorized Member

"MGR" = Manager

Member

**Name and Address:**

Florida IPS Medical Services, LLC

6200 S. Syracuse Way, Ste. 200

Greenwood Village, CO 80111

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14 JUL 10 PM 1:12

(Use attachment if necessary)


**ARTICLE V:** Effective date, if other than the date of filing: upon filing (OPTIONAL)

(If an effective date is listed, the date must be specific and cannot be more than five business days prior to or 90 days after the date of filing.)

**ARTICLE VI:** Other provisions, if any.

none

**REQUIRED SIGNATURE:**

\*  \*

Signature of a member or an authorized representative of a member.  
(In accordance with section 605.0203 (1) (b), Florida Statutes, the execution of this document constitutes an affirmation under the penalties of perjury that the facts stated herein are true. I am aware that any 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.)

Terry Meadows, M.D. - authorized signer

Typed or printed name of signee

**Filing Fees:**

\$125.00 Filing Fee for Articles of Organization and Designation of Registered Agent

\$ 30.00 Certified Copy (Optional)

\$ 5.00 Certificate of Status (Optional)