

M20000002090

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

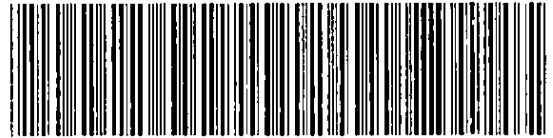
(Business Entity Name)

(Document Number)

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

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Office Use Only



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2000 FEB 21 PM 12:36

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500  
2/21/20


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

ACCOUNT NO. : I20000000195

REFERENCE : 188023 7297236

AUTHORIZATION :

COST LIMIT : \$125.00



ORDER DATE : February 20, 2020

ORDER TIME : 2:19 PM

ORDER NO. : 188023-010

CUSTOMER NO: 7297236

FOREIGN FILINGS

NAME: HIGHCROSS HEALTHCARE ADVISORS  
LLC

XXXX QUALIFICATION (TYPE: LL)

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

           CERTIFIED COPY  
XX            PLAIN STAMPED COPY  
           CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Kadesha Roberson -- EXT# 62980

EXAMINER: \_\_\_\_\_

2020 FEB 21 PM 12:36

**COVER LETTER**

**TO: Registration Section  
Division of Corporations**

**SUBJECT:** HighCross Healthcare Advisors LLC

Name of Limited Liability Company

The enclosed "Application by Foreign Limited Liability Company for Authorization to Transact Business in Florida," Certificate of Existence, and check are submitted to register the above referenced foreign limited liability company to transact business in Florida.

Please return all correspondence concerning this matter to the following:

Dane C. Andreeff

Name of Person

HighCross Healthcare Advisors LLC

Firm/Company

140 E. St. Lucia Lane

Address

Santa Rosa Beach, FL 32459

City/State and Zip Code

dane@mapleleafunds.com

E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Dane C. Andreeff

225

803-7967

at ( )

Name of Contact Person

Area Code

Daytime Telephone Number

**Mailing Address:**

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

**Street Address:**

Registration Section  
Division of Corporations  
The Centre of Tallahassee  
2415 N. Monroe Street, Suite 810  
Tallahassee, FL 32303

Enclosed is a check for the following amount:

Please make check payable to: **FLORIDA DEPARTMENT OF STATE**

☐ \$125.00 Filing Fee

☐ \$130.00 Filing Fee &  
Certificate of Status

☐ \$155.00 Filing Fee &  
Certified Copy

☐ \$160.00 Filing Fee, Certificate  
of Status & Certified Copy

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APPLICATION BY FOREIGN LIMITED LIABILITY COMPANY FOR AUTHORIZATION TO TRANSACT BUSINESS  
IN FLORIDA

IN COMPLIANCE WITH SECTION 605.0902, FLORIDA STATUTES, THE FOLLOWING IS SUBMITTED TO REGISTER A FOREIGN LIMITED LIABILITY COMPANY TO TRANSACT BUSINESS IN THE STATE OF FLORIDA:

1. HighCross Healthcare Advisors LLC  
(Name of Foreign Limited Liability Company; must include "Limited Liability Company," "L.L.C.," or "LLC.")

(If name unavailable, enter alternate name adopted for the purpose of transacting business in Florida. The alternate name must include "Limited Liability Company," "L.L.C.," or "LLC.")

2. Delaware  
(Jurisdiction under the law of which foreign limited liability company is organized)

3. \_\_\_\_\_  
(FEI number, if applicable)

4. \_\_\_\_\_  
(Date first transacted business in Florida, if prior to registration.)  
(See sections 605.0904 & 605.0905, F.S. to determine penalty liability)

5. 140 E. St. Lucia Lane  
(Street Address of Principal Office)

6. 140 E. St. Lucia Lane  
(Mailing Address)

Santa Rosa Beach, FL 32459

Santa Rosa Beach, FL 32459

7. Name and street address of Florida registered agent: (P.O. Box NOT acceptable)

Name: Corporation Service Company

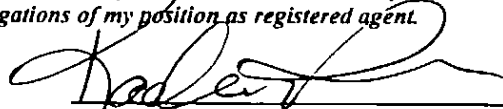
Office Address: 1201 Hays Street

Tallahassee, Florida 32301  
(City) (Zip code)

2020 FEB 21 PM 12:

Registered agent's acceptance:

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 application, 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 relative to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent.



(Registered agent's signature)

Kadesha Roberson  
Asst. Vice President

8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers or persons authorized to manage [up to six (6) total]:

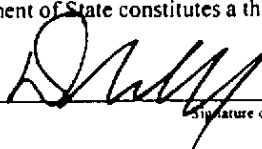
<u>Title or Capacity:</u>	<u>Name and Address:</u>	<u>Title or Capacity:</u>	<u>Name and Address:</u>
<input type="checkbox"/> Manager	Name: <u>Dane C. Andreeff</u>	<input type="checkbox"/> Manager	Name: _____
<input checked="" type="checkbox"/> Member	Address: <u>140 E. St. Lucia Lane</u>	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	<u>Santa Rosa Beach, FL 32459</u>	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
 <input type="checkbox"/> Manager	 Name: _____	 <input type="checkbox"/> Manager	 Name: _____
<input type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	_____	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
 <input type="checkbox"/> Manager	 Name: _____	 <input type="checkbox"/> Manager	 Name: _____
<input type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	_____	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

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**Important Notice:** Use an attachment to report more than six (6). The attachment will be imaged for reporting purposes only. Non-indexed individuals may be added to the index when filing your Florida Department of State Annual Report form.

9. Attached is a certificate of existence, no more than 90 days old, duly authenticated by the official having custody of records in the jurisdiction under the law of which it is organized. (If the certificate is in a foreign language, a translation of the certificate under oath of the translator must be submitted)

10. This document is executed in accordance with section 605.0203 (1) (b), Florida Statutes. 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.

  
 \_\_\_\_\_  
 Signature of an authorized person  
 Dane C. Andreeff  
 \_\_\_\_\_  
 Typed or printed name of signer

# Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "HIGHCROSS HEALTHCARE ADVISORS LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-FIRST DAY OF FEBRUARY, A.D. 2020.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "HIGHCROSS HEALTHCARE ADVISORS LLC" WAS FORMED ON THE TWENTIETH DAY OF FEBRUARY, A.D. 2020.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.

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SR# 20201360822

You may verify this certificate online at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)

A handwritten signature of Jeffrey W. Bullock in black ink, written over a horizontal line.

Jeffrey W. Bullock, Secretary of State

Authentication: 202435173

Date: 02-21-20