

W22000664335

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

(Business Entity Name)

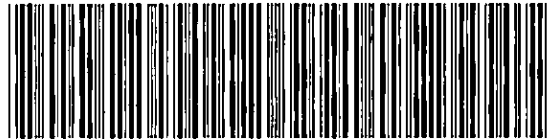
(Document Number)

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2022 MAR 16 AM 11:11

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RECEIVED

ALABAMA SECRETARY OF REVENUE

S. FRANKLIN

MAR 24 2022

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

ACCOUNT NO. : I20000000195

REFERENCE : 552721 8190358

AUTHORIZATION : *Spurlockman*

COST LIMIT : \$ 916.25

ORDER DATE : March 15, 2022

ORDER TIME : 10:24 AM

ORDER NO. : 552721-005

CUSTOMER NO: 8190358

FOREIGN FILINGS

NAME: THREE SEASONS HEALTHCARE 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: Alexxis Weiland -- EXT#

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

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COVER LETTER

TO: Registration Section  
Division of Corporations

SUBJECT: THREE SEASONS HEALTHCARE 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:

JOSEPH D. VECCHIOLLA

Name of Person

THREE SEASONS HEALTHCARE LLC

Firm/Company

One N Clematis St Suite 110

Address

West Palm Beach , FL. 33401

City/State and Zip Code

jv@3scapital.com

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

For further information concerning this matter, please call:

Joseph D. Vecchiolla

312

307-7171

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. THREE SEASONS HEALTHCARE 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. 85-0628864

(FEI number, if applicable)

4. 5/1/2020

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

5. 1 N. Clematis St

(Street Address of Principal Office)

6. 1 N. Clematis St

(Mailing Address)

Ste 110

Ste 110

West Palm Beach, FL 33401

West Palm Beach, FL 33401

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

Name:

Corporation Service Company

Office Address:

1201 Hays St

Tallahassee

(City)

Florida 32301

(Zip code)

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67160

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.

Alexis Weibnd, assistant va president  
(Registered agent's signature)


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 checked="" type="checkbox"/> Manager	Name: Fred Drasner	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 1 N. Clematis ST	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	Ste 110	<input type="checkbox"/> Authorized	_____
Person	West Palm Beach, FL 33401	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Manager	Name: Joseph Vecchiolla	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 2552 NW 12th Cir	<input type="checkbox"/> Member	Address: _____
<input checked="" type="checkbox"/> Authorized	Camas, WA 98607	<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 _____

**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  
Joseph D. Vecchiolla, Chief Financial Officer  
\_\_\_\_\_  
Typed or printed name of signee

# Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "THREE SEASONS HEALTHCARE 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 FIFTEENTH DAY OF MARCH, A.D. 2022.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "THREE SEASONS HEALTHCARE LLC" WAS FORMED ON THE SIXTH DAY OF APRIL, A.D. 2020.

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

2022 MAR 16 AM 11:11



  
Jeffrey W. Bullock, Secretary of State

7924082 8300

SR# 20221016572

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

Authentication: 202920789

Date: 03-15-22