

2000 UNIFORM BUSINESS REPORT (UBR)

Pg 1 of 2

DOCUMENT # P25223

1. Entity Name
CHARTER HOSPITAL OF ST. LOUIS, INC.

FILED

00 SEP 13 PM 3:22

**SECRETARY OF STATE
TALLAHASSEE, FLORIDA**

Principal Place of Business
6950 COLUMBIA GATEWAY DR
COLUMBIA MD 21046
US

Mailing Address
577 MULBERRY ST.
MACON GA 31202



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business
Suite, Apt. #, etc.
City & State
Zip

3. Mailing Address
1450 Columbia Gateway Drive
Suite, Apt. #, etc.
Suite 400
City & State
Columbia MD 21046
Zip
Howard

4. FEI Number **58-1583760**
Applied For
 Not Applicable

5. Certificate of Status Desired **\$8.75 Additional Fee Required**

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**THE PRENTICE-HALL CORPORATION SYSTEM, INC.
1201 HAYS STREET
TALLAHASSEE FL 32301**

Name
Street Address (P.O. Box Number is Not Acceptable)
City **FL** Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.

SIGNATURE _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating.)

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so.
(See criteria on back)

FILE NOW!!! FEE IS \$550.00
After SEPTEMBER 13, 2000 Min. will be \$750.00
Make Check Payable to Department of State

10. Election Campaign Financing Trust Fund Contribution. **\$5.00 May Be Added to Fees**

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P BROWN, D. KEITH 3414 PEACHTREE RD NE, STE 1400 ATLANTA GA 30326	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V NEWLIN, LINTON C 577 MULBERRY ST MACON GA 31202	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VPAS MARGIE M. SMITH 577 MULBERRY ST. MACON GA 31202	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D J. KEVIN HELMINTOLLER 3414 PEACHTREE RD NE, STE 1400 ATLANTA GA 30326	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S ANCOSKY, MICHELLE H 3414 PEACHTREE RD NE, STE 1400 ATLANTA GA 30326	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DT SANFORD, CHARLOTTE A 3414 PEACHTREE RD NE, STE 1400 ATLANTA GA	<input type="checkbox"/> Delete

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P/D Clarissa C. Marques 6950 Columbia Gateway Dr, # 400 Columbia MD 21046	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	200003392192--3	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V/S/D Mark S. Demilio 6950 Columbia Gateway Dr, # 400 Columbia MD 21046	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T/D Charlotte A. Sanford 4666 Powers Ferry Road Atlanta, GA 30339	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition

13. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: *Mark S. Demilio* **REQUIRED** **9/8/00** **410/953-4702**
Signature, typed or printed name of signing officer or director. Date Daytime Phone #

MARK S. DEMILIO, VP & SECRETARY

CR2E034 (5/00)

98292



ACCOUNT NO. : 072100000032

REFERENCE : 827597 5028257

AUTHORIZATION :

Patricia Pizito

COST LIMIT : \$ 550.00

ORDER DATE : September 12, 2000

ORDER TIME : 9:50 AM

ORDER NO. : 827597-015

CUSTOMER NO: 5028257

CUSTOMER: Ms. Maria Ayub
Magellan Health Services, Inc.
6950 Columbia Gateway Drive
Suite 400
Columbia, MD 21046

ANNUAL REPORT FILING

NAME: CHARTER HOSPITAL OF ST. LOUIS, INC.

RECEIVED
00 SEP 13 AM 10:44
DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
TALLAHASSEE, FL 32310

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

- CERTIFIED COPY
- XX PLAIN STAMPED COPY
- CERTIFICATE OF GOOD STANDING

CONTACT PERSON: ~~Allison Smith~~ - Ext. 1155

Janna Wilson
EXAMINER'S INITIALS: _____