

2001 UNIFORM BUSINESS REPORT (UBR)

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0577106

DOCUMENT # P25223

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

FILED

01 APR 30 PM 3:04

SECRETARY OF STATE
 TALLAHASSEE, FLORIDA



DO NOT WRITE IN THIS SPACE

Principal Place of Business Mailing Address

**6950 COLUMBIA GATEWAY DR
 COLUMBIA MD 21046
 US** **6950 COLUMBIA GATEWAY DRIVE, STE 400
 COLUMBIA MD 21046**

2. Principal Place of Business 3. Mailing Address

Suite, Apt. #, etc. Suite, Apt. #, etc.

City & State City & State

Zip Country Zip Country

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

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

7. Name and Address of New Registered Agent

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 \$150.00
 After MAY 1, 2001 Fee will be \$550.00
 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	
TITLE	PD <input type="checkbox"/> Delete
NAME	MARQUES, CLARISSA C
STREET ADDRESS	6950 COLUMBIA GATEWAY DR., #400
CITY-ST-ZIP	COLUMBIA MD 21046
TITLE	V <input type="checkbox"/> Delete
NAME	NEWLIN, LINTON C
STREET ADDRESS	577 MULBERRY ST - 125 Plantation Center Dr
CITY-ST-ZIP	MACON GA 31202 31221
TITLE	VPAS <input type="checkbox"/> Delete
NAME	SMITH, MARGIE M
STREET ADDRESS	577 MULBERRY ST. 125 Plantation Center Dr
CITY-ST-ZIP	MACON GA 31202 31221
TITLE	VSD <input type="checkbox"/> Delete
NAME	DEMILIO, MARK S
STREET ADDRESS	6950 COLUMBIA GATEWAY DR., #400
CITY-ST-ZIP	COLUMBIA MD 21046
TITLE	TD <input type="checkbox"/> Delete
NAME	SANFORD, CHARLOTTE A
STREET ADDRESS	666 POWERS FERRY ROAD
CITY-ST-ZIP	ATLANTA GA 30339
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	200004090652--9
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

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* Mark S. Demilio, Vice President 4/24/01
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/00)



ACCOUNT NO. : 072100000032
 REFERENCE : 131817 5028257
 AUTHORIZATION : *Patricia Pizito*
 COST LIMIT : \$ 150.00

ORDER DATE : April 27, 2001
 ORDER TIME : 9:48 AM
 ORDER NO. : 131817-060
 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.

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

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

CONTACT PERSON: Deborah Schroder - Ext. 1118

EXAMINER'S INITIALS:

RECEIVED
 DEPARTMENT OF STATE
 DIVISION OF CORPORATIONS
 2001 APR 30 AM 10:43
 NOT INTENDED
 TO ACKNOWLEDGE
 SUFFICIENCY OF FILING