

2015 FLORIDA PROFIT CORPORATION ANNUAL REPORT

DOCUMENT# P04000069890

Entity Name: GRANT CENTER HOSPITAL OF OCALA, INC.**Current Principal Place of Business:**ONE PARK PLAZA
NASHVILLE, TN 37203**Current Mailing Address:**PO BOX 750
NASHVILLE, TN 37203 US**FEI Number:** 20-1066482**Certificate of Status Desired:** No**Name and Address of Current Registered Agent:**C T CORPORATION SYSTEM
1200 SOUTH PINE ISLAND ROAD
PLANTATION, FL 33324 US*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:**_____
Electronic Signature of Registered Agent_____
Date**Officer/Director Detail :**

Title	P
Name	CUFFE, MICHAEL
Address	THREE MARYLAND FARMS, STE. 250
City-State-Zip:	BRENTWOOD TN 37027

Title	DVPA
Name	FRANCK , JOHN M II
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	VPT
Name	GIGER, KEITH M
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	DSVP
Name	STINNETT, DONALD W
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	DSVP
Name	RUTHERFORD, WILLIAM B
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	VPS
Name	CLINE, NATALIE H
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 above, or on an attachment with all other like empowered.

SIGNATURE: NATALIE H. CLINE

VPS

04/26/2015

Electronic Signature of Signing Officer/Director Detail_____
Date