

2000 UNIFORM BUSINESS REPORT (UBR)

PS192

DOCUMENT # G52664

1. Entity Name

FLORIDA HEALTH FACILITIES, INC.

FILED

00 SEP 13 PM 3:32

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business

6950 COLUMBIA GATEWAY DR
COLUMBIA MD 21046
US

Mailing Address

577 MULBERRY STREET
MACON GA 31202

2. Principal Place of Business

3. Mailing Address

6950 Columbia Gateway Drive

Suite, Apt. #, etc.

Suite, Apt. #, etc.

Suite 400

City & State

City & State
Columbia MD

4. FEI Number

58-1860493

Applied For

Not Applicable

Zip

Country

Zip

21046

Country

Howard

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

DO NOT WRITE IN THIS SPACE



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

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

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 D ☒ Delete
NAME J. KEVIN HELMINTOLLER
STREET ADDRESS 3414 PEACHTREE RD NE, STE 1400
CITY-ST-ZIP ATLANTA GA 30326

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS 700003392187--8
CITY-ST-ZIP

TITLE DP ☒ Delete
NAME BROWN, D. KEITH
STREET ADDRESS 3414 PEACHTREE RD NE, STE 1400
CITY-ST-ZIP ATLANTA GA 30326

TITLE D/P ☒ Change ☐ Addition
NAME Clarissa C. Marques
STREET ADDRESS 6950 Columbia Gateway Drive, Suite 400
CITY-ST-ZIP Columbia MD 21046

TITLE S ☒ Delete
NAME ANCOSKY, MICHELLE H
STREET ADDRESS 3414 PEACHTREE RD NE, STE 1400
CITY-ST-ZIP ATLANTA GA 30326

TITLE D/V/S ☒ Change ☐ Addition
NAME Mark S. Demilio
STREET ADDRESS 6950 Columbia Gateway Drive, Suite 400
CITY-ST-ZIP Columbia MD 21046

TITLE VPAS ☐ Delete
NAME MARGIE M. SMITH
STREET ADDRESS 577 MULBERRY ST.
CITY-ST-ZIP MACON GA 31202

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE VP ☐ Delete
NAME NEWLIN, LINTON C
STREET ADDRESS 577 MULBERRY ST.
CITY-ST-ZIP MACON GA 31202

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE TD ☐ Delete
NAME SANFORD, CHARLOTTE A
STREET ADDRESS 3414 PEACHTREE RD NE, STE 1400
CITY-ST-ZIP ATLANTA GA

TITLE TD ☒ Change ☐ Addition
NAME Charlotte A. Sanford
STREET ADDRESS 6666 Powers Ferry Road, # 100
CITY-ST-ZIP Atlanta GA 30339

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:

SIGNATURE REQUIRED

9/8/00

410-953-4702

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

MARK S. DEMILIO, VPE SECRETARY

CR2E034 (5/00)

pg 2 of 2



ACCOUNT NO. : 072100000032

REFERENCE : 827597 5028257

AUTHORIZATION :

COST LIMIT : \$ 550.00

Tatiana Pizot

ORDER DATE : September 12, 2000

ORDER TIME : 9:56 AM

ORDER NO. : 827597-055

CUSTOMER NO: 5028257

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

ANNUAL REPORT FILING

NAME: FLORIDA HEALTH FACILITIES,
INC.

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

Tanna W. 150

EXAMINER'S INITIALS: _____

RECEIVED
00 SEP 13 AM 10:44
DEPARTMENT OF STATE
DIVISION OF CORPORATE REGISTRATION
TALLAHASSEE, FLORIDA