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2007 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

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07 APR 30 AM 9:37

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # N36505

1. Entity Name
CLEVELAND CLINIC FLORIDA HOSPITAL (A NONPROFIT CORPORATION)

Principal Place of Business	Mailing Address
3100 WESTON ROAD WESTON, FL 33331	1950 RICHMOND ROAD, TR-38 ATTN: KERRIE KRIZNER LYNDHURST, OH 44124

03192007 Chg-NP CR2E037 (12/06)

2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 65-0172168 ☐ 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
ANDREW SERVICE CORPORATION OF FLORIDA 201 N. FRANKLIN STREET SUITE 2100 TAMPA, FL 33602	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. I am familiar with, and accept the obligations of registered agent.

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

Filing Fee is $61.25
Due by May 1, 2007

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

Make check payable to Florida Department of State

10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10		
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	ED KAY, ROBERT M.D. 2950 CLEVELAND CLINIC BLVD. WESTON, FL 33331	☒ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	CFO Steve C. Glass 9500 Euclid Ave., H-18 Cleveland, OH 44195	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	COOT O'BOYLE, MICHAEL 9500 EUCLID AVE. CLEVELAND, OH 44195	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	CFO Scott Campbell 2950 Cleveland Clinic Blvd. Weston, FL 33331	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	S ROWAN, DAVID W 9500 EUCLID AVE. CLEVELAND, OH 44195	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	T Joseph F. Hahn, M.D. 9500 Euclid Ave., H-18 Cleveland, OH 44195	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	T KAY, ROBERT MD 9500 EUCLID AVE CLEVELAND, OH 44195	☒ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	T MIXON, A. MALACHI III 9500 EUCLID AVE. CLEVELAND, OH 44195	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	40009892824	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	CEOT COSGROVE, DELOS M M.D. 9500 EUCLID AVENUE H-18 CLEVELAND, OH 44195	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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 617, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: _____ David W Rowan 216-297-7071
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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CORPORATION SERVICE COMPANY®

ACCOUNT NO. : 072100000032

REFERENCE : 864362 7402817

AUTHORIZATION :

COST LIMIT : $ 61.25

ORDER DATE : April 23, 2007

ORDER TIME : 12:34 PM

ORDER NO. : 864362-025

CUSTOMER NO: 7402817

ANNUAL REPORT FILING

NAME: CLEVELAND CLINIC FLORIDA HOSPITAL

RECEIVED
DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
2007 APR 30 PM 3:19
TO ACKNOWLEDGE
SUFFICIENCY OF FILING

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

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

CONTACT PERSON: Sara Lea - Ext. 2914

EXAMINER'S INITIALS: _____