

2002 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # N92000000973

1. Entity Name

HIALEAH HOSPITAL PHO, INC.

Principal Place of Business

Mailing Address

651 E 25TH STREET
HIALEAH FL 33013

651 E 25TH STREET
HIALEAH FL 33013

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

65-0384664

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

FERNANDEZ, AURELIO M
651 EAST 25TH STREET
HIALEAH FL 33015

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

FILE NOW: FEE IS \$61.25

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

Make Check Payable to
Department of State

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PSD FERNANDEZ, AURELIO M 651 EAST 25TH STREET HIALEAH FL <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	CD MITJANS, AURELIO MD 651 EAST 25TH STREET HIALEAH FL <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DT GONZALEZ, AURELIO 651 EAST 25TH STREET HIALEAH FL <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

12. 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 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:

[Signature] REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

FILED
Feb 21, 2002 8:00 am
Secretary of State

02-21-2002 90138 025 ****61.25



DO NOT WRITE IN THIS SPACE

CR2E037 (9/01)

Attachment Doc#
N9200000973
740825

8-Jan

	Total Beds	Budgeted ADC	Avail. Bed at 8a	Restrains 7-Jan	Private Duties	8-Jan		
						5p	12m	8a
ICU/CCU	21	18	1	0	0	20	19	20
Annex Total	22	10	4	0	0	18	18	18
Medical	60	46	22	0	205a	35	35	38
Med-Peds	13	8	13	0	0	0	0	0
IMCU	57	50	0	0	322b, 326a&b	57	57	57
ICU/Med Surg Total	173	132	40	0	4	130	129	133
NICU	10	7	8	0	0	2	2	2
OB/GYN	32	14	19	0	0	9	10	13
L&D	8		3	0	0	5	6	5
Adult Total	223	153	59	0	4	152	156	164
Newborns			7	0		8	8	9
Surgery	16						13	28
L&D Outpatients							3	
L&D Surg(other CS)							0	
Deliveries							6	
ER Visits last 24 hrs.							75	
Admitted ER visits							25	
Holding Patients				0		6	9	11
Admissions (Total)							48	
Discharges (Total)							20	
Admissions (Adult)							43	
Discharges (Adult)							16	
OBS PT (Inc. in Total)							1	

***Restraint Data Unavail.

6 ICU 9Step 3Tel

6ICU 3Step 2ICU
16Admit 25ER 2Surg 5NBN