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2007 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

DOCUMENT # N96000004380

1. Entity Name
CLEVELAND CLINIC FLORIDA HEALTH SYSTEM
NONPROFIT CORPORATION

FILED

07 APR 30 AM 9: 03

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business	Mailing Address
6101 PINE RIDGE RD. NAPLES, FL 34119	1950 RICHMOND ROAD, TR-38 ATTN: KERRIE KRIZNER LYNDHURST, OH 44124

2. Principal Place of Business - No P.O. Box #	3. Mailing Address
2950 Cleveland Clinic Blvd.	
Suite, Apt. #, etc.	Suite, Apt. #, etc.

03192007 Chg-NP CR2E037 (12/06)

City & State	City & State	4. FEI Number	Applied For
Weston, FL		65-0844880	Not Applicable

Zip	Country	Zip	Country	5. Certificate of Status Desired ☐	**$8.75** Additional Fee Required
33331	USA				

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 33602-5164	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.

900099892209

SIGNATURE _____

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

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	ED	☒ Delete	TITLE	CEO	☐ Change ☒ Addition
NAME	KAY, ROBERT MD		NAME	Bernardo Fernandez, M.D.	
STREET ADDRESS	2950 CLEVELAND CLINIC BLVD.		STREET ADDRESS	2950 Cleveland Clinic Blvd.	
CITY-ST-ZIP	WESTON, FL 33331		CITY-ST-ZIP	Weston, FL 33331	
TITLE	COO	☐ Delete	TITLE	COO	☐ Change ☒ Addition
NAME	O'BOYLE, MICHAEL		NAME	Marty Sargeant	
STREET ADDRESS	9500 EUCLID AVENUE		STREET ADDRESS	2950 Cleveland Clinic Blvd.	
CITY-ST-ZIP	CLEVELAND, OH 44195		CITY-ST-ZIP	Weston, FL 33331	
TITLE	S	☐ Delete	TITLE	CEO & Trustee	☐ Change ☒ Addition
NAME	ROWAN, DAVID W		NAME	Delos H. Cosgrove, M.D.	
STREET ADDRESS	9500 EUCLID AVE.		STREET ADDRESS	9500 Euclid Ave., H-18	
CITY-ST-ZIP	CLEVELAND, OH 44195		CITY-ST-ZIP	Cleveland, OH 44195	
TITLE	AS	☐ Delete	TITLE	Trustee	☐ Change ☒ Addition
NAME	MEEHAN, MICHAEL J		NAME	Joseph F. Hahn, M.D.	
STREET ADDRESS	9500 EUCLID AVE.		STREET ADDRESS	9500 Euclid Ave., H-18	
CITY-ST-ZIP	CLEVELAND, OH 44195		CITY-ST-ZIP	Cleveland, OH 44195	
TITLE	CFO	☐ Delete	TITLE		☐ Change ☐ Addition
NAME	GLASS, STEVEN C		NAME		
STREET ADDRESS	9500 EUCLID AVE.		STREET ADDRESS		
CITY-ST-ZIP	CLEVELAND, OH 44195		CITY-ST-ZIP		
TITLE	CFO	☐ Delete	TITLE		☐ Change ☐ Addition
NAME	CAMPBELL, SCOTT		NAME		
STREET ADDRESS	2950 CLEVELAND CLINIC BLVD.		STREET ADDRESS		
CITY-ST-ZIP	WESTON, FL 33331		CITY-ST-ZIP		

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 #

CSC.

CORPORATION SERVICE COMPANY

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ACCOUNT NO.    :  072100000032

  REFERENCE    :  864362      7402817

AUTHORIZATION  :

   COST LIMIT  :  $ 61.25
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ORDER DATE : April 23, 2007

ORDER TIME : 12:30 PM

ORDER NO. : 864362-010

CUSTOMER NO: 7402817

<u>ANNUAL REPORT FILING</u>

NAME: CLEVELAND CLINIC FLORIDA
          HEALTH SYSTEM

<u>XX</u>   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: _____