DATE	DOCUMENT ID	DESCRIPTION	FILING	EXPED	PENALTY	CERT	COPY
07/15/2024	202419702958	BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION (24A)	25.00				0

Receipt

This is not a bill. Please do not remit payment.

KELLY GREANEY
265 BROOKVIEW CENTRE WAY, SUITE 203
KNOXVILLE, TN, 37919

STATE OF OHIO
CERTIFICATE

Ohio Secretary of State, Frank LaRose

1975025

It is hereby certified that the Secretary of State of Ohio has custody of the business records for

HOSPITAL MEDICINE ASSOCIATES OF OHIO, PROFESSIONAL CORPORATION

and, that said business records show the filing and recording of:

Document(s)	Document No(s):
BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION	**202419702958**

Effective Date: 07/15/2024

United States of America
State of Ohio
Office of the Secretary of State

Witness my hand and the seal of the Secretary of State at Columbus, Ohio this 15th day of July, A.D. 2024.

Ohio Secretary of State

Form 520 Prescribed by:

Date Electronically Filed: 7/15/2024

Toll Free: 877.767.3453 | Central Ohio: 614.466.3910

OhioSoS.gov | business@OhioSoS.gov

File online or for more information: OhioBusinessCentral.gov

Biennial Report

(Domestic, Professional Association, Domestic or Foreign LLP)

Filing Fee: $25

Form Must Be Typed

CHECK ONLY ONE (1) Box

(1) ☒ 2024 Indicate Year — Biennial Report of Professional Association (102-YRA) (even-numbered years)

List Profession: MEDICAL

(2) ☐ _____ Indicate Year — Biennial Report of Limited Liability Partnership (103-YRL) (odd-numbered years)

If foreign limited liability partnership, provide jurisdiction of formation: _____

Name of Entity: HOSPITAL MEDICINE ASSOCIATES OF OHIO, PROFESSIONAL CORPORATION

Charter or Registration Number: 1975025

Complete the information in this section if box (1) is checked

Shareholders of Professional Association

Authenticating this form constitutes a certification that all the below listed shareholders are duly licensed or otherwise legally authorized to render the professional services in this state in the profession that is listed above.

Name	Address
WILLIAM COLE, MD	265 BROOKVIEW CENTRE WAY, STE 203 KNOXVILLE T

Complete the applicable information in this section if box (2) is checked

Address of the partnership's chief executive office:

Mailing Address

City | State | Zip Code

If the chief executive office is not in Ohio, the address of any office of the partnership in Ohio:

Mailing Address

City | State | Zip Code

If the partnership does not have an office in Ohio, the name and address of the partnership's current agent for service of process:

Name of Agent

Mailing Address

City | State | Zip Code

By signing and submitting this form to the Ohio Secretary of State, the undersigned hereby certifies that he or she has the requisite authority to execute this document.

Required
Report must be signed by an officer of the professional association or partner or authorized representative of the partnership.

If authorized representative is an individual, then they must sign in the "signature" box and print their name in the "Print Name" box.

JOHN R STAIR
Signature

By (if applicable)

Print Name

If authorized representative is a business entity, not an individual, then please print the business name in the"signature" box, an authorized representative of the business entity must sign in the "By" box and print their name in the "Print Name" box.