



Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

OAK CREEK MEDICAL CENTER OWNERS ASSOCIATION INC
1023 N HIGHLAND AVE
MURFREESBORO, TN 37130

June 7, 2023

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	001434046	Formation Locale:	TENNESSEE
Filing Type:	For-profit Corporation - Domestic	Date Formed:	06/06/2023
Filing Date:	06/06/2023 1:28 PM	Shares of Stock:	1,000
Status:	Active	Fiscal Year Close:	12
Duration Term:	Perpetual	Annual Report Due:	04/01/2024
Business County:	RUTHERFORD COUNTY	Image # :	B1395-5191

Document Receipt

Receipt # : 008158259	Filing Fee:	\$100.00
Payment-Check/MO - OAK CREEK MEDICAL CENTER OWNERS ASSOCIATION INC, MURFRI		\$100.00

Registered Agent Address:

DILESH PATEL
1023 N HIGHLAND AVE
MURFREESBORO, TN 37130

Principal Address:

1023 N HIGHLAND AVE
MURFREESBORO, TN 37130

Congratulations on the successful filing of your **Charter** for **OAK CREEK MEDICAL CENTER OWNERS ASSOCIATION INC** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (www.tn.gov/revenue) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Processed By: Cynthia Dunn


Tre Hargett
Secretary of State



**CHARTER
FOR-PROFIT CORPORATION**

SS-4417



Tre Hargett
Secretary of State

**Division of Business Services
Department of State**
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: \$100.00

For Office Use Only

FILED

The undersigned, acting as incorporator(s) of a for-profit corporation under the provisions of the Tennessee Business Corporation Act, adopt the following Articles of Incorporation.

1. The name of the corporation is: OAK CREEK MEDICAL CENTER OWNERS ASSOCIATION INC
(Note: Pursuant to the provisions of T.C.A. §48-14-101(a)(1), each corporation name must contain the words corporation, incorporated, or company or the abbreviation corp., inc., or co.)

2. Name Consent: (Written Consent for Use of Indistinguishable Name)
☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of: None

4. The name and complete address of its initial registered agent and office located in the State of Tennessee is:
DILESH PATEL
~~1045 N HIGHLAND AVE~~ 1023 N HIGHLAND AVE
MURFREESBORO, TN 37130
RUTHERFORD COUNTY

5. Fiscal Year Close Month: December Period of Duration: Perpetual

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is:
(none) (Not to exceed 90 days)

7. The corporation is for profit.

8. The number of shares of stock the corporation is authorized to issue is: 1,000

9. The complete address of its principal office is:
~~1045 N HIGHLAND AVE~~ 1023 N HIGHLAND AVE
MURFREESBORO, TN 37130
RUTHERFORD COUNTY
Email: universalrehab@yahoo.com

(Note: Pursuant to T.C.A. §10-7-503 all information on this form is public record.)

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CHARTER
FOR-PROFIT CORPORATION

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The name of the corporation is: OAK CREEK MEDICAL CENTER OWNERS ASSOCIATION INC

10. The complete mailing address of the entity (if different from the principal office) is:
~~4045 N HIGHLAND AVE~~ 1023 N HIGHLAND AVE
MURFREESBORO, TN 37130

11. List the name and complete address of each incorporator:

Title	Name	Business Address	City, State, Zip
Incorporator	DILESH PATEL	4045 N HIGHLAND AVE 1023	MURFREESBORO, TN 37130

12. Professional Corporation: (required if the additional designation of "Professional Corporation" is entered in section 3.)
☐ I certify that this is a Professional Corporation.
Licensed Profession:

13. Other Provisions:

(Note: Pursuant to T.C.A. §10-7-503 all information on this form is public record.)

Electronic Signature	Incorporator Title/Signer's Capacity
DILESH PATEL	May 18, 2023 2:13PM
Printed Name	Date

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**CHANGE OF ADDRESS**

Complete this form to notify the Department of Revenue of address changes for your account.

1. CHECK ALL TAX TYPES AFFECTED BY THIS CHANGE:☐ SALES or USE TAX☒ FRANCHISE and EXCISE TAXES☐ TOBACCO TAX**ALCOHOLIC BEVERAGES TAXES:**

☐ Beer Barrelage
☐ Brand Registration
☐ Liquor-by-the-Drink
☐ Wholesale Beer
☐ Wholesale Gallonage

GROSS RECEIPTS TAXES:

☐ Bottlers
☐ Mixing Bars
☐ Gas, Water, Electric
Power & Light

PRIVILEGE TAXES:

☐ Auto Rental Surcharge
☐ Bail Bondsmen
☐ Business Tax
☐ Litigation Tax
☐ Professional Privilege Tax
☐ Realty Transfer and Mortgage Tax

SOLID WASTE TAXES:

☐ Tire
☐ Used Oil

SEVERANCE TAXES:

☐ Coal
☐ Crude Oil/Natural Gas
☐ Mineral

☐ **MOTOR FUEL TAXES**☐ OTHER TAX (Please specify) _____**2. TAXPAYER'S LEGAL NAME AND CURRENT INFORMATION REFLECTED IN DEPARTMENT OF REVENUE RECORDS.**Name: OAK CREEK MEDICAL CENTER OW

Phone Number: _____

Street: 1045 N HIGHLAND AVE

FEIN/SSN: _____

City, State, Zip: MURFREESBORO, TN 37130

Tax Account No: _____

3. PLACE (a), (b), or (c), AS APPROPRIATE, IN THE SPACE NEXT TO THE ADDRESS BEING CHANGED.☒ Mailing Address☒ Location Address☒ Primary Address☐ Power of Attorney☐ Personal Representative☐ Attorney☐ Other (Please specify): _____**3(a). New Address and Identifying Information**

Name: _____
Street: 1023 N HIGHLAND AVE
City, State, Zip: MURFREESBORO, TN 37130
Phone Number: _____

FEIN/SSN: _____
Tax Account No: _____
Fax No: _____
E-mail Address: _____

3(b). New Address and Identifying Information

Name: _____
Street: _____
City, State, Zip: _____
Phone Number: _____

FEIN/SSN: _____
Tax Account No: _____
Fax No: _____
E-mail Address: _____

3(c). New Address and Identifying Information

Name: _____
Street: _____
City, State, Zip: _____
Phone Number: _____

FEIN/SSN: _____
Tax Account No: _____
Fax No: _____
E-mail Address: _____

When all required blocks are fully and correctly completed, sign below.

4. I declare that the information on this application is correct and complete to the best of my knowledge and belief.

Print Name: DILESH PATELSign Here: Patel Dilesh J.Date: 05/24/2023**DEPARTMENT USE ONLY**