

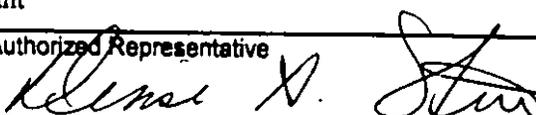
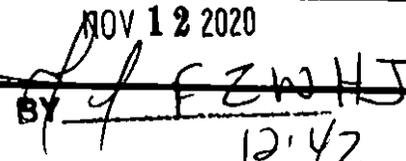
State of Rhode Island
Department of State - Business Services Division

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 R.I. DEPT. OF STATE
 BUS SVCS DIV

Annual Report for the year: 2020
Corporation

2020 NOV 12 P 12:39

- Filing period: January 1 - March 1
- Filing Fee: \$50.00
- Penalty: Additional \$25.00 fee if form is not filed by April 1.

1. Entity ID Number 1665730		2. Exact name of the Corporation Comprehensive Behavioral Health Care, Inc.			
3. Principal Office Address 227 West Main Road			City Middletown	State RI	Zip 02842
4. NAICS Code 621112		6. Brief description of the character of business conducted in Rhode Island Behavioral Health Care Services			
5. State of Incorporation Rhode Island					
7. List ALL officers (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
President Name Denise Fleurant			Vice-President Name		
Street Address 552 West Main Road			Street Address		
City Little Compton	State RI	Zip 02837	City	State	Zip
Secretary Name			Treasurer Name Denise Fleurant		
Street Address			Street Address 552 West Main Road		
City	State	Zip	City Little Compton	State RI	Zip 02837
8. List ALL directors (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
Director Name			Director Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Director Name			Director Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
9. Shares Authorized			10. Shares Issued Check the box to indicate an attachment <input type="checkbox"/>		
This information is currently of record in the Department of State. Changes require an additional filing.			NUMBER OF SHARES	CLASS/SERIES	PAR VALUE
			100.00	CWP	\$0.0010
11. This report must be executed on behalf of the corporation by an authorized representative. If the corporation is in the hands of a receiver or trustee, this report must be executed on behalf of the corporation by the receiver or trustee. Under penalty of perjury, I declare and affirm that I have examined this report, including any accompanying schedules and statements, and that all statements contained herein are true and correct.					
Name of Authorized Representative Denise Fleurant				FILED	Date 03/20/2020
Signature of Authorized Representative 				NOV 12 2020 BY  12:42	