



State of Rhode Island
Department of State - Business Services Division

Annual Report for the year: 2024

2025 JAN -7 PM 12:17

Corporation

- Filing period: February 1 - May 1
→ Filing Fee: \$50.00
→ Penalty: Additional \$25.00 fee if form is not filed by May 31.

| | | | | | |
|---|-------------|---|--|---------------------|--|
| 1. Entity ID Number 000086364 | | 2. Exact name of the Corporation University Surgical Alliance, Inc. | | | |
| 3. Principal Office Address 110 Elm Street | | | City Providence | State RI | Zip 02903 |
| 4. NAICS Code 621111 | | 6. Brief description of the character of business conducted in Rhode Island To act as a general partner to limited partnerships. | | | |
| 5. State of Incorporation RI | | | | | |
| 7. List ALL officers (names and addresses) | | | | | Check the box to indicate an attachment <input type="checkbox"/> |
| President Name Aurora Pryor, MD | | | Vice-President Name | | |
| Street Address 110 Elm Street, 2nd Floor | | | Street Address | | |
| City Providence | State RI | Zip 02903 | City | State | Zip |
| Secretary Name | | | Treasurer Name | | |
| Street Address | | | Street Address | | |
| City | State | Zip | City | State | Zip |
| 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 | | |
| This information is currently of record in the Department of State. | | | Check the box to indicate an attachment <input type="checkbox"/> | | |
| Changes require an additional filing. | | | NUMBER OF SHARES 900 | CLASS SERIES CNP | PART VALUE 0 |
| 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 Robin M. Martin | | | | Date 01/03/2025 | |
| Signature of Authorized Representative | | | | | |

MAIL TO:
Division of Business Services
148 W. River Street, Providence, Rhode Island 02904-2615
Phone: (401) 222-3040
Website: www.sos.ri.gov

FILED

JAN 07 2025

BY *H6VQ*

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