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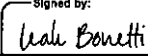


**State of Rhode Island**  
**Department of State - Business Services Division**

Annual Report for the year: **2019****Corporation**

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

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 FOR  
 SECRETARY OF STATE  
 USE ONLY

1. Entity ID Number <b>000083987</b>		2. Exact name of the Corporation <b>HealthCare Data Corporation</b>			
3. Principal Office Address <b>200 Carillon Parkway, Suite 200</b>			City <b>St. Petersburg</b>	State <b>FL</b>	Zip <b>33556</b>
4. NAICS Code <b>511210</b>		6. Brief description of the character of business conducted in Rhode Island <b>To develop and market electronic drug healthcare information systems.</b>			
5. State of Incorporation <b>Delaware</b>					
7. List ALL officers (names and addresses) <span style="float: right;">Check the box to indicate an attachment <input type="checkbox"/></span>					
President Name <b>Vacant</b>			Vice-President Name <b>Vacant</b>		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Secretary Name			Treasurer Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
8. List ALL directors (names and addresses) <span style="float: right;">Check the box to indicate an attachment <input type="checkbox"/></span>					
Director Name <b>Vacant</b>			Director Name <b>Vacant</b>		
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 <span style="float: right;">Check the box to indicate an attachment <input type="checkbox"/></span>		
This information is currently of record in the Department of State.  Changes require an additional filing.			NUMBER OF SHARES		
			CLASS/SERIES		
			PAR VALUE		
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. <i>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.</i>					
Name of Authorized Representative <b>Leah Bonetti</b>				Date <b>07/17/2025</b>	
Signature of Authorized Representative Signed by: 					

**FILED 9:20 A****MAIL TO:**

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

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