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State of Rhode Island
Department of State - Business Services Division

Annual Report for the year: **2017**

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 000083987 | | 2. Exact name of the Corporation HealthCare Data Corporation | | | |
| 3. Principal Office Address 200 Carillon Parkway, Suite 200 | | | City St. Petersburg | State FL | Zip 33556 |
| 4. NAICS Code 511210 | | 6. Brief description of the character of business conducted in Rhode Island To develop and market electronic drug healthcare information systems. | | | |
| 5. State of Incorporation Delaware | | | | | |
| 7. List ALL officers (names and addresses) Check the box to indicate an attachment <input type="checkbox"/> | | | | | |
| President Name Vacant | | | Vice-President Name Vacant | | |
| 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) Check the box to indicate an attachment <input type="checkbox"/> | | | | | |
| Director Name Vacant | | | Director Name Vacant | | |
| 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 | | |
| | | | 100 | Common | 0.0100 |
| | | | | | |
| 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 Leah Bonetti | | | | Date 07/17/2025 | |
| Signature of Authorized Representative <i>Signed by:</i> | | | | | |

FILED 9:18 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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FORM 630- Revised: 12/2023