


# 2004 LIMITED LIABILITY COMPANY ANNUAL REPORT

<b>DOCUMENT # M03000001777</b> 1. Entity Name <b>ADVANCEPCS HEALTH SYSTEMS, LLC</b>	
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Principal Place of Business <b>750 WEST JOHN CARPENTER FREEWAY STE. 1200 IRVING, TX 75039</b>	Mailing Address <b>750 WEST JOHN CARPENTER FREEWAY STE. 1200 IRVING, TX 75039</b>
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2. Principal Place of Business <b>9501 E. Shea Blvd.</b> Suite, Apt. #, etc. <b>Scottsdale, AZ</b>	3. Mailing Address <b>211 Commerce Street</b> Suite, Apt. #, etc. <b>Suite 800</b>
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City & State <b>City &amp; State Nashville, TN</b>	City & State <b>City &amp; State Nashville, TN</b>
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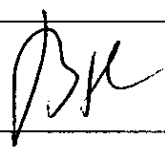
Zip <b>85260</b>	Country <b>USA</b>	Zip <b>37201</b>	Country <b>USA</b>
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6. Name and Address of Current Registered Agent  <b>CORPORATION SERVICE COMPANY 1201 HAYS STREET TALLAHASSEE, FL 32301-2525</b>	7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <div style="display: flex; justify-content: space-between;"> <span><b>FL</b></span> <span>Zip Code</span> </div>
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8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE

<b>Filing Fee is \$50.00 Due by September 8, 2004</b>		<b>Make check payable to Florida Department of State</b>
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9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE	MGRM <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	ADVANCEPCS HOLDING CORP	NAME	
STREET ADDRESS	750 WEST JOHN CARPENTER FREEWAY, STE 1200	STREET ADDRESS	
CITY-ST-ZIP	IRVING, TX 75039	CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	<b>500040266595</b>
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	

11. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE:  **Sara J. Finley** 8/11/04 615-743-6600  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #

**FILED**  
 04 AUG 17 AM 9:24  
 SECRETARY OF STATE  
 TALLAHASSEE, FLORIDA



08112004 Chg-LLC CR2E083 (10/03)

4. FEI Number <b>75-2945835</b>	Applied For Not Applicable
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5. Certificate of Status Desired ☐ **\$5.00** Additional Fee Required



CORPORATION SERVICE COMPANY

MO3000001777

ACCOUNT NO. : 072100000032

REFERENCE : 851091 7416132

AUTHORIZATION : Patricia Pizeto

COST LIMIT : \$ 50.00

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

04 AUG 17 AM 9:24

FILED

ORDER DATE : August 17, 2004

ORDER TIME : 2:32 PM

ORDER NO. : 851091-040

CUSTOMER NO: 7416132

CUSTOMER: Gina R. Clark  
Caremark Rx, Inc.  
8th Floor  
211 Commerce St.  
Nashville, TN 37201

DEPARTMENT OF STATE  
DIVISION OF CORPORATIONS  
TALLAHASSEE, FLORIDA

04 AUG 17 PM 4:12

RECEIVED

ANNUAL REPORT FILING

NAME: ADVANCEPCS HEALTH SYSTEMS, LLC

XX ANNUAL REPORT

BK

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

\_\_\_\_ CERTIFIED COPY  
XX PLAIN STAMPED COPY  
\_\_\_\_ CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Darlene Ward-EXT#2935

EXAMINER'S INITIALS: \_\_\_\_\_