2013 ANNUAL REPORT
COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

21308.0946--5/3/2013

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1. CORPORATION NAME:
   LEARNING RESEARCH, INC.

DUE DATE: **06/30/13**

2. VA REGISTERED AGENT NAME AND OFFICE ADDRESS: ATTY.
   CHARLES W. LAUGHLIN

   100 Shockoe Slip, 3rd Fl.

   Richmond, VA 23219

SCC ID NO.: **0393471-8**

3. CITY OR COUNTY OF VA REGISTERED OFFICE:
   216-RICHMOND CITY

5. STOCK INFORMATION

CLASS	AUTHORIZED
COMMON	4,000

4. STATE OR COUNTRY OF INCORPORATION:
   VA-VIRGINIA

DO NOT ATTEMPT TO ALTER THE INFORMATION ABOVE. Carefully read the enclosed instructions. Type or print in black only.

6. PRINCIPAL OFFICE ADDRESS:

☐ Mark this box if address shown below is correct	If the block to the left is blank or contains incorrect data please add or correct the address below.
ADDRESS: 420 N.W. FIFTH ST., SUITE 3B	ADDRESS:
CITY/ST/ZIP EVANSVILLE, IN 47708	CITY/ST/ZIP

7. DIRECTORS AND PRINCIPAL OFFICERS: All directors and principal officers must be listed.
   An individual may be designated as both a director and an officer.

Mark appropriate box unless area below is blank: ☐ Information is correct ☐ Information is incorrect ☐ Delete information	If the block to the left is blank or contains incorrect data, please mark appropriate box and enter information below: ☐ Correction ☐ Addition ☐ Replacement
OFFICER ☒ DIRECTOR ☒	OFFICER ☐ DIRECTOR ☐
NAME: ALAN R BRILL	NAME:
TITLE: P/S/T	TITLE:
ADDRESS: 420 NW FIFTH ST STE 3B'	ADDRESS:
CITY/ST/ZIP: EVANSVILLE, IN 47708	CITY/ST/ZIP:

I affirm that the information contained in this report is accurate and complete as of the date below.

_____
SIGNATURE OF DIRECTOR/OFFICER
LISTED IN THIS REPORT

_____ALAN BRILL_____
PRINTED NAME AND CORPORATE TITLE

__4-30-13__
DATE

It is a Class 1 misdemeanor for any person to sign a document that is false in any material respect with intent that the document be delivered to the Commission for filing.

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LEARNING RESEARCH, INC.

DUE DATE: 06/30/13
SCC ID NO.: 0393471-8

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7. DIRECTORS AND PRINCIPAL OFFICERS (continued):

Mark appropriate box unless area below is blank: [ ] Information is correct [ ] Information is incorrect [ ] Delete information	If the block to the left is blank or contains incorrect data, please mark appropriate box and enter information below: [ ] Correction [ ] Addition [ ] Replacement
OFFICER ☒ DIRECTOR ☐ NAME: ROB FONCANNON TITLE: ASST SECRETARY ADDRESS: 420 NW 5TH ST CITY/ST/ZIP: EVANSVILLE, IN 47708	**OFFICER ☐ DIRECTOR [ ]** NAME: TITLE: ADDRESS: CITY/ST/ZIP:
Mark appropriate box unless area below is blank: [ ] Information is correct [ ] Information is incorrect [ ] Delete information	If the block to the left is blank or contains incorrect data, please mark appropriate box and enter information below: [ ] Correction [ ] Addition [ ] Replacement
OFFICER ☐ DIRECTOR ☐ NAME: TITLE: ADDRESS: CITY/ST/ZIP:	**OFFICER ☐ DIRECTOR [ ]** NAME: TITLE: ADDRESS: CITY/ST/ZIP:
Mark appropriate box unless area below is blank: [ ] Information is correct [ ] Information is incorrect [ ] Delete information	If the block to the left is blank or contains incorrect data, please mark appropriate box and enter information below: [ ] Correction [ ] Addition [ ] Replacement
OFFICER ☐ DIRECTOR ☐ NAME: TITLE: ADDRESS: CITY/ST/ZIP:	**OFFICER ☐ DIRECTOR ☐** NAME: TITLE: ADDRESS: CITY/ST/ZIP:
Mark appropriate box unless area below is blank: [ ] Information is correct [ ] Information is incorrect [ ] Delete information	If the block to the left is blank or contains incorrect data, please mark appropriate box and enter information below: [ ] Correction [ ] Addition [ ] Replacement
OFFICER ☐ DIRECTOR ☐ NAME: TITLE: ADDRESS: CITY/ST/ZIP:	**OFFICER ☐ DIRECTOR ☐** NAME: TITLE: ADDRESS: CITY/ST/ZIP:

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