



State of Rhode Island
and Providence Plantations
Office of the Secretary of State

A. Ralph Molis, Secretary of State
Corporations Division
148 W. River Street
Providence, RI 02904-2615
401.222.3040

LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2009

Filing Period: September 1 - November 1 • **Filing Fee:** \$50.00

In accordance with R.I.G.L. 7-16-66 (d), each limited liability company failing or refusing to file its annual report within thirty (30) days after the time prescribed by law (R.I.G.L. 7-16-66 (b&c)) is subject to a penalty fee of \$25.00.

1. ID No. 275837		2. Exact name of the limited liability company NEW 1200, LLC	
3. State of Formation RHODE ISLAND		4. Brief description of the character of the business which is actually conducted in Rhode Island LEASE REAL ESTATE	
5. Principal office address 245 ATWELLS AVENUE		City PROVIDENCE	State RI
		Zip 02903	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:			
Contact Name JAMES K. CARDI, MD		Contact Title	
Street Address 245 ATWELLS AVENUE		City PROVIDENCE	State RI
		Zip 02903	
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE - DO NOT LIST MEMBERS FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>			
Manager Name NONE		Manager Name	
Street Address		Street Address	
City	State	Zip	City
Manager Name		Manager Name	
Street Address		Street Address	
City	State	Zip	City
8. RESIDENT AGENT IN RHODE ISLAND - DO NOT ALTER - Changes require filing of Form 642 - R.I.G.L. 7-16-11			
Agent Name E. COLBY CAMERON		Address	
Address 301 PROMENADE STREET		City PROVIDENCE	Zip 02908

FILED

NOV 23 2009

By 104457

This report must be executed by an authorized person pursuant to R.I.G.L. 7-16-66 (b).

NOV 23 11:55

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.

J. Cardi
Signature of Authorized Person
Date 10.21.09
JAMES K. CARDI, MD
Print or Type Name of Authorized Person

File Date _____
Check No. _____
By: _____
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