



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

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

**LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2011**

**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. 87423		2. Exact name of the limited liability company ORTHOPEDIC REALTY ASSOCIATES, LLC			
3. State of Formation RHODE ISLAND		4. Brief description of the character of the business which is actually conducted in Rhode Island REAL ESTATE			
5. Principal office address ONE HIGH STREET		City WAKEFIELD	State RI	Zip 02879	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name RICHARD MAILLOUX		Contact Title PRACTICE ADMINISTRATOR			
Street Address ONE HIGH STREET		City WAKEFIELD	State RI	Zip 02879	
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE - <b>DO NOT LIST MEMBERS</b> FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>					
Manager Name ROBERT C. MARCHAND, M.D.		Manager Name			
Street Address ONE HIGH STREET		Street Address			
City WAKEFIELD	State RI	Zip 02879	City	State	Zip
Manager Name		Manager Name			
Street Address		Street Address			
City	State	Zip	City	State	Zip
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		

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

87423

**FILED**

OCT 21 2011

By 154803  
DS

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.

Robert Mollis 10/20/11  
Signature of Authorized Person Date

**ROBERT C. MARCHAND, M.D., MANAGER**

Print or Type Name of Authorized Person

File Date \_\_\_\_\_  
Check No. \_\_\_\_\_  
By: \_\_\_\_\_  
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