



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
Office of the Secretary of State - Division of Business Services  
148 W. River Street, Providence, Rhode Island 02904-2615  
Phone: (401) 222-3040, ~ Email: corporations@sos.ri.gov ~ Website: www.sos.ri.gov

## LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR **2013**

Filing Period: September 1 - November 1 • This report must be typed or printed legibly.

Filing Fee: \$50.00 • FAILURE TO FILE THIS REPORT BY DECEMBER 1 WILL RESULT IN A \$25.00 PENALTY FEE.

1. Entity ID No. <b>136549</b>		2. Exact name of the limited liability company <b>Shoreline Medical Imaging, LLC</b>	
3. State of Formation <b>RHODE ISLAND</b>		4. Brief description of the character of business conducted in Rhode Island <b>ACQUIRE, OWN, DEVELOP, SELL, INVEST IN AND/OR LEASE REAL ESTATE &amp; MEDICAL &amp; OTHER EQUIPMENT</b>	
5. Principal office address <b>P.O. BOX 609</b>		City <b>LEDYARD</b>	State <b>CT</b>
		Zip <b>06339</b>	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:			
Contact Name <b>DANIEL DIFFIN, M.D.</b>		Contact Title	
Street Address <b>P.O. BOX 609</b>		City <b>LEDYARD</b>	State <b>CT</b>
		Zip <b>06339</b>	
7. LIST <u>ALL</u> MANAGERS (NAMES AND ADDRESSES) OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE - <b>DO NOT LIST MEMBERS</b> ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>			
Manager Name <b>NONE</b>		Manager Name	
Street Address		Street Address	
City	State	Zip	City
			State
			Zip
Manager Name		Manager Name	
Street Address		Street Address	
City	State	Zip	City
			State
			Zip
8. RESIDENT AGENT IN RHODE ISLAND			
This information is currently of record in the Office of the Secretary of State. Changes require filing Form 642.			

File Date \_\_\_\_\_

Check No \_\_\_\_\_

By: \_\_\_\_\_

FOR SECRETARY OF STATE USE ONLY

**FILED**

SEP 30 2013

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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.

Signature of Authorized Person

Date

**Daniel Diffin, M.D.; Michael Niles, M.D.**

Print or Type Name of Authorized Person