



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. 787856 | | 2. Exact name of the limited liability company Barry W. Wall, M.D., LLC | | | |
| 3. State of Formation Rhode Island | | 4. Brief description of the character of business conducted in Rhode Island To provide psychiatric counseling and any other lawful purpose. | | | |
| 5. Principal office address 184 Waterman Street | | City Providence | State RI | Zip 02906 | |
| 6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON: | | | | | |
| Contact Name Barry W. Wall, M.D. | | Contact Title Sole Member | | | |
| Street Address 184 Waterman Street | | City Providence | State RI | Zip 02906 | |
| 7. LIST ALL MANAGERS (NAMES AND ADDRESSES) OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE - DO NOT LIST MEMBERS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/> | | | | | |
| Manager Name | | 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. | | | | | |

FILED

NOV 19 2013

BY 2355

File Date _____

Check No _____

By: _____

FOR SECRETARY OF STATE USE ONLY

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

Barry W. Wall, M.D.

Print or Type Name of Authorized Person