



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 2014

Filing Period: September 1 - November 1 • **Filing Fee:** \$50.00* • **THIS REPORT MUST BE TYPED OR PRINTED LEGIBLY IN BLACK INK.**

* 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. 126412		2. Exact name of the limited liability company Cumberland Medical Associates, LLC			
3. State of Formation Rhode Island		4. Brief description of the character of the business which is actually conducted in Rhode Island The operation and management of the condominium.			
5. Principal office address 725 Reservoir Avenue, Suite 101		City Cranston		State RI	Zip 02910
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name A. Louis Mariorenzi, M.D.		Contact Title Member			
Street Address 725 Reservoir Avenue, Suite 101		City Cranston		State RI	Zip 02910
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) ☐					
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 of Form 642 - R.I.G.L. 7-16-11					

FILED

SEP 29 2014

BY 3-26

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

126412

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 **9/22/14**
A. Louis Mariorenzi, MD
Print or Type Name of Authorized Person

File Date _____
Check No. _____
By: _____
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