



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 2015

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 DANIEL LABRADOR			Contact Title		
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 - DO NOT LIST MEMBERS FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) ☐					
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

OCT 26 2015

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

ROBERT C. MARCHAND, M.D., MANAGER

Print or Type Name of Authorized Person

File Date _____
Check No. _____
By: _____

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