



**LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2005**

Filing Period: September 1 - November 1 • Filing Fee: \$50.00

(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. ID No. 134153		2. Exact name of the limited liability company Broadway Medical Treatment Center, LLC	
3. State of Formation RHODE ISLAND		4. Brief description of the character of the business which is actually conducted in Rhode Island MEDICAL TREATMENT CENTER	
5. Principal office address P.O. BOX 824		City BLOCK ISLAND	State RI
		Zip 02807-	
<b>6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:</b>			
Contact Name STEPHEN J DIGIANFILLIPPO		Contact Title	
Street Address 50 PARK ROW WEST, SUITE 111		City PROVIDENCE	State RI
		Zip 02903-	
<b>7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE</b>			
FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>			
ANY MODIFICATIONS TO MANAGERS REQUIRES FILING OF AMENDMENT. R.I.G.L. 7-16-12 (a) (2) / 7-16-52			
Manager Name Peter G. Brassard		*Manager Name	
Street Address 35 Bluff Road		*Street Address	
City Barrington	State RI	Zip 02806	*City
			*State
			*Zip
*Manager Name		*Manager Name	
*Street Address		*Street Address	
City	State	Zip	*City
			*State
			*Zip
<b>8. RESIDENT AGENT IN RHODE ISLAND - DO NOT ALTER - Changes require filing of Form 642 - R.I.G.L. 7-16-11.</b>			
Agent Name STEPHEN J. DIGIANFILIPPO, ESQ.		Address 50 PARK ROW WEST, SUITE 111	
Address Vieira & DiGianfilippo Ltd.		City PROVIDENCE	Zip 02903-

This report must be signed in ink by an authorized person pursuant to 7-16-66.



1 3 4 1 5 3

\*134153 DLLC 11/04/2005 12:56 PM\*

**FILED**

File Date: NOV 04 2005

Check No. 1014

By: KWC A 81580

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]* 11/26/05  
Signature of Authorized Person Date

Peter G. Brassard, Manager  
Print or Type Name of Authorized Person



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5. Principal office address P.O. BOX 824			City BLOCK ISLAND	State RI	Zip 02807-
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name Stephen J. DiGianfilippo, Esq.			Contact Title Attorney		
Street Address 50 Park Row West, Suite 111			City Providence	State RI	Zip 02903
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/> ANY MODIFICATIONS TO MANAGERS REQUIRES FILING OF AMENDMENT. R.I.G.L. 7-16-12 (a) (2) / 7-16-52					
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Address .			City PROVIDENCE	Zip 02903-	

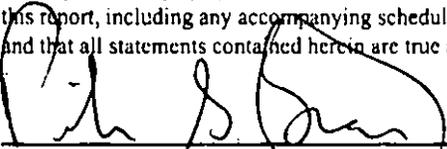
This report must be signed in ink by an authorized person pursuant to 7-16-66.



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*134153 DLLC 09/16/04 04:11:20 PM*
File Date <u>10/28/04</u>
Check No. <u>0205</u>
By: <u>W.</u>
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.

 10/25/04  
Signature of Authorized Person Date

Peter G. Brassard, Manager  
Print or Type Name of Authorized Person