



**PROFIT CORPORATION ANNUAL REPORT FOR THE YEAR 2005**

Filing Period: January 1 - March 1 • Filing Fee: \$50.00  
(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. Corporate ID No. 112362		2. Name of Corporation Whole Health Physical Therapy, Inc.			
3. Street Address Principal Business Office 407 East Ave.		STE 110	City Pawtucket	State RI	Zip 02860
4. Business Phone No. 401-722-2225		5. State of Incorporation RHODE ISLAND			6. SIC Code 9431
7. Brief Description of the Character of Business Conducted in Rhode Island TO PROVIDE PHYSICAL THERAPY SERVICES.					
8. NAMES AND ADDRESSES OF THE OFFICERS: ("X" BOX FOR ATTACHMENT) <input checked="" type="checkbox"/> <input type="checkbox"/> FILL IN SPACES BEFORE USING ATTACHMENTS					
President Name Elizabeth Demers			Vice President Name Denise Leclaire		
Street Address 9 Hampton St.			Street Address 200 Farm St.		
City Barrington	State RI	Zip 02806	City Blackstone	State MA	Zip 01504
Secretary Name Elizabeth Demers			Treasurer Name Denise Leclaire		
Street Address 9 Hampton St.			Street Address 200 Farm St.		
City Barrington	State RI	Zip 02806	City Blackstone	State MA	Zip 01504
9. NAMES AND ADDRESSES OF THE DIRECTORS: ("X" BOX FOR ATTACHMENT) <input checked="" type="checkbox"/> <input type="checkbox"/> FILL IN SPACES BEFORE USING ATTACHMENTS					
Director Name Elizabeth Demers			Director Name Denise Leclaire		
Street Address 9 Hampton St.			Street Address 200 Farm St.		
City Barrington	State RI	Zip 02806	City Blackstone	State MA	Zip 01504
Director Name none			Director Name none		
Street Address			Street Address		
City	State	Zip	City	State	Zip
10. SHARES AUTHORIZED ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>			11. SHARES ISSUED ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>		
AUTHORIZED SHARES			ISSUED SHARES		
Number of Shares	Class/Series	Par Value	Number of Shares	Class/Series	Par Value
1,000	NO PAR VALUE		none		

This report must be signed in ink by either the President, Vice President, Secretary, Assistant Secretary, Treasurer, Receiver or Trustee



File Date 1/10/05  
Check No. 1397  
By: W.  
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.

Denise Leclaire 1/6/05  
Signature of Officer Date  
Denise Leclaire  
Print or Type Name of Officer  
Vice President  
Title of Officer

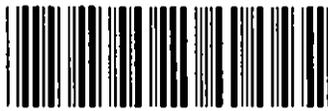


**PROFIT CORPORATION ANNUAL REPORT FOR THE YEAR 2004**

Filing Period: January 1 - March 1 • Filing Fee: \$50.00  
(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. Corporate ID No. 112362		2. Name of Corporation Whole Health Physical Therapy, Inc.			
3. Street Address: Principal Business Office 100 Randall Street			City Providence	State RI	Zip 02904
4. Business Phone No. 401-824-0114		5. State of Incorporation RHODE ISLAND			6. SIC Code 9431
7. Brief Description of the Character of Business Conducted in Rhode Island TO PROVIDE PHYSICAL THERAPY SERVICES.					
8. NAMES AND ADDRESSES OF THE OFFICERS: ("X" BOX FOR ATTACHMENT) <input type="checkbox"/> FILL IN SPACES BEFORE USING ATTACHMENTS					
President Name Elizabeth Demers			Vice President Name Denise Leclaire		
Street Address 9 Hampden Street			Street Address 200 Farm Street		
City Barrington	State RI	Zip 02806	City Blackstone	State MA	Zip 01504
Secretary Name Elizabeth Demers			Treasurer Name Denise Leclaire		
Street Address 9 Hampden Street			Street Address 200 Farm Street		
City Barrington	State RI	Zip 02806	City Blackstone	State MA	Zip 01504
9. NAMES AND ADDRESSES OF THE DIRECTORS: ("X" BOX FOR ATTACHMENT) <input type="checkbox"/> FILL IN SPACES BEFORE USING ATTACHMENTS					
Director Name Elizabeth Demers			Director Name Denise Leclaire		
Street Address 9 Hampden Street			Street Address 200 Farm Street		
City Barrington	State RI	Zip 02806	City Blackstone	State MA	Zip 01504
Director Name			Director Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
10. SHARES AUTHORIZED ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>					
AUTHORIZED SHARES			11. SHARES ISSUED ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>		
ISSUED SHARES			ISSUED SHARES		
Number of Shares	Class/Series	Par Value	Number of Shares	Class/Series	Par Value
1,000 NO PAR VALUE			none	none	none

This report must be signed in ink by either the President, Vice President, Secretary, Assistant Secretary, Treasurer, Receiver or Trustee



\* 1 1 2 3 6 2 \*

File Date 1-20-04  
Check No. 1221  
By: [Signature]  
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] 1/15/04  
Signature of Officer Date  
Denise Leclaire  
Print or Type Name of Officer  
Vice president  
Title of Officer



**PROFIT CORPORATION ANNUAL REPORT FOR THE YEAR 2003**  
Filing Period: January 1-March 1 • Filing Fee: \$50.00

(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. Corporate ID No. **112362** 2. Name of Corporation **Whole Health Physical Therapy, Inc.**  
3. Street Address Principal Business Office **100 Randall Street** City **Providence** State **RI** Zip **02904**  
4. Business Phone No. **401-824-0114** 5. State of Incorporation **RHODE ISLAND** 6. SIC Code **9431**  
7. Brief Description of the Character of Business Conducted in Rhode Island

**Servicing Rehabilitative Physical Therapy care(out-patient)**

8. NAMES AND ADDRESSES OF THE OFFICERS (\*X\* BOX FOR ATTACHMENT) **FILL IN SPACES BEFORE USING ATTACHMENTS**

President Name <b>Elizabeth Demers</b> Street Address <b>9 Hampden Street</b> City <b>Barrington</b> State <b>RI</b> Zip <b>02806</b>	Vice President Name <b>Denise Leclaire</b> Street Address <b>200 Farm Street</b> City <b>Blackstone</b> State <b>MA</b> Zip <b>01504</b>
Secretary Name <b>Elizabeth Demers</b> Street Address <b>9 Hampden Street</b> City <b>Barrington</b> State <b>RI</b> Zip <b>02806</b>	Treasurer Name <b>Denise Leclaire</b> Street Address <b>200 Farm Street</b> City <b>Blackstone</b> State <b>MA</b> Zip <b>01504</b>

9. NAMES AND ADDRESSES OF THE DIRECTORS (\*X\* BOX FOR ATTACHMENT) **FILL IN SPACES BEFORE USING ATTACHMENTS**

Director Name <b>Elizabeth Demers</b> Street Address <b>9 Hampden Street</b> City <b>Barrington</b> State <b>RI</b> Zip <b>02806</b>	Director Name <b>Denise Leclaire</b> Street Address <b>200 Farm Street</b> City <b>Blackstone</b> State <b>MA</b> Zip <b>01504</b>
Director Name <b>none</b> Street Address <b>none</b> City <b>none</b> State <b>none</b> Zip <b>none</b>	Director Name <b>none</b> Street Address <b>none</b> City <b>none</b> State <b>none</b> Zip <b>none</b>

10. SHARES AUTHORIZED (\*X\* BOX FOR ATTACHMENT)

AUTHORIZED SHARES	Class/Series	Par Value
<b>1,000 NO PAR VALUE</b>		

11. SHARES ISSUED (\*X\* BOX FOR ATTACHMENT)

ISSUED SHARES	Class/Series	Par Value
<b>none</b>	<b>none</b>	<b>none</b>

This report must be signed in ink by either the President, Vice President, Secretary, Assistant Secretary, Treasurer, Receiver or Trustee



\* 1 1 2 3 6 2 \*

File Date: 1-17-03  
Check No: 1075  
By: UP

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.

Denise Leclaire 01/14/03  
Signature of Officer Date

Denise Leclaire  
Print or Type Name of Officer

Vice President/Treasurer  
Title of Officer



**PROFIT CORPORATION ANNUAL REPORT FOR THE YEAR 2002**  
Filing Period: January 1-March 1 • Filing Fee: \$50.00



(FORM MUST BE TYPED IN BLACK)

1. Corporate ID No. **112362** 2. Name of Corporation **Whole Health Physical Therapy, Inc.**  
3. Street Address Principal Business Office **100 Randall Street** City **Providence** State **RI** Zip **02904**  
4. Business Phone No. **401-824-0114** 5. State of Incorporation **RHODE ISLAND** 6. SIC Code **9431**  
7. Brief Description of the Character of Business Conducted in Rhode Island  
**Out-patient Physical Therapy rehabilitation services**

8. NAMES AND ADDRESSES OF THE OFFICERS (\*X\* BOX FOR ATTACHMENT) **FILL IN SPACES BEFORE USING ATTACHMENTS**

President Name <b>Elizabeth Ann Demers</b> Street Address <b>22 Brook Farm Rd.</b> City <b>N. Providence</b> State <b>RI</b> Zip <b>02904</b>	Vice President Name <b>Denise Lee Leclaire</b> Street Address <b>200 Farm St.</b> City <b>Blackstone</b> State <b>MA</b> Zip <b>01504</b>
Secretary Name <b>Elizabeth Ann Demers</b> Street Address <b>22 Brook Farm Rd</b> City <b>N. Providence</b> State <b>RI</b> Zip <b>02904</b>	Treasurer Name <b>Denise Lee Leclaire</b> Street Address <b>200 Farm St.</b> City <b>Blackstone</b> State <b>MA</b> Zip <b>01504</b>

9. NAMES AND ADDRESSES OF THE DIRECTORS (\*X\* BOX FOR ATTACHMENT) **FILL IN SPACES BEFORE USING ATTACHMENTS**

Director Name <b>Elizabeth Ann Demers</b> Street Address <b>22 Brook Farm Rd.</b> City <b>N. Providence</b> State <b>RI</b> Zip <b>02904</b>	Director Name <b>Denise Lee Leclaire</b> Street Address <b>200 Farm St.</b> City <b>Blackstone</b> State <b>MA</b> Zip <b>01504</b>
Director Name <b>none</b> Street Address  City _____ State _____ Zip _____	Director Name <b>none</b> Street Address  City _____ State _____ Zip _____

10. SHARES AUTHORIZED (\*X\* BOX FOR ATTACHMENT)

AUTHORIZED SHARES	Class/Series	Par Value
<b>1,000 NO PAR VALUE</b>		

11. SHARES ISSUED (\*X\* BOX FOR ATTACHMENT)

ISSUED SHARES	Class/Series	Par Value
<b>none</b>		

This report must be signed in ink by either the President, Vice President, Secretary, Assistant Secretary, Treasurer, Receiver or Trustee



\* 1 1 2 3 6 2 \*

File Date: 1-10-02  
1158  
Check No.: \_\_\_\_\_  
By: [Signature]

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.

Denise L. Leclaire 1/8/02  
Signature of Officer Date  
Denise L. Leclaire  
Print or Type Name of Officer  
Vice president  
Title of Officer



**PROFIT CORPORATION ANNUAL REPORT FOR THE YEAR 2001**

Filing Period: January 1-March 1 • Filing Fee: \$50.00



(FORM MUST BE TYPED IN BLACK)

1. Corporate ID No. <b>112362</b>		2. Name of Corporation <b>Whole Health Physical Therapy, Inc.</b>	
3. Street Address Principal Business Office <b>100 Randall Street</b>		City <b>Providence</b>	State <b>RI</b>
4. Business Phone No. <b>401-824-0114</b>		5. State of Incorporation <b>RHODE ISLAND</b>	6. SIC Code <b>9431</b>
7. Brief Description of the Character of Business Conducted in Rhode Island <b>Physical Therapy rehabilitative services</b>			
8. NAMES AND ADDRESSES OF THE OFFICERS (*X* BOX FOR ATTACHMENT) <input type="checkbox"/> <b>FILL IN SPACES BEFORE USING ATTACHMENTS</b>			
President Name <b>Elizabeth A. Demers</b>		Vice President Name <b>Denise L. Leclaire</b>	
Street Address <b>22 Brookfarm Rd.</b>		Street Address <b>200R Farm Street</b>	
City <b>N. Providence</b>	State <b>RI</b>	Zip <b>02904</b>	City <b>Blackstone</b>
Secretary Name <b>Elizabeth A. Demers</b>		Treasurer Name <b>Denise L. Leclaire</b>	
Street Address <b>22 Brookfarm Rd.</b>		Street Address <b>200R Farm Street</b>	
City <b>N. Providence</b>	State <b>RI</b>	Zip <b>02904</b>	City <b>Blackstone</b>
9. NAMES AND ADDRESSES OF THE DIRECTORS (*X* BOX FOR ATTACHMENT) <input type="checkbox"/> <b>FILL IN SPACES BEFORE USING ATTACHMENTS</b>		11. SHARES ISSUED (*X* BOX FOR ATTACHMENT) <input type="checkbox"/>	
Director Name <b>Elizabeth A. Demers</b>		Director Name <b>Denise L. Leclaire</b>	
Street Address <b>22 Brookfarm Rd.</b>		Street Address <b>200R Farm Street</b>	
City <b>N. Providence</b>	State <b>RI</b>	Zip <b>02904</b>	City <b>Blackstone</b>
10. SHARES AUTHORIZED (*X* BOX FOR ATTACHMENT) <input type="checkbox"/>		11. SHARES ISSUED (*X* BOX FOR ATTACHMENT) <input type="checkbox"/>	
AUTHORIZED SHARES		ISSUED SHARES	
Number of Shares	Class/Series	Par Value	Number of Shares
<b>1,000 NO PAR VALUE</b>			<b>none</b>
			<b>none</b>
			<b>none</b>

This report must be signed in ink by either the President, Vice President, Secretary, Assistant Secretary, Treasurer, Receiver or Trustee



\* 1 1 2 3 6 2 \*

**FILED**

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

Check No.: **FEB 05 2001**

By: **CA 1043**

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.

*Denise L. Leclaire* 2/3/01  
Signature of Officer Date

**Denise L. Leclaire**  
Print or Type Name of Officer

**Vice president / Treasurer**  
Title of Officer