



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.

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|---|--------------------|---|--------------------|---------------------|-----|
| 1. Entity ID No. 631424 | | 2. Exact name of the limited liability company INTEGRATIVE LYME CENTER OF RHODE ISLAND, LLC | | | |
| 3. State of Formation RHODE ISLAND | | 4. Brief description of the character of business conducted in Rhode Island TO PROVIDE PATIENT CARE | | | |
| 5. Principal office address 35 SOUTH ANGELL STREET | | City PROVIDENCE | State RI | Zip 02906 | |
| 6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON: | | | | | |
| Contact Name DONNA ZAKEN | | Contact Title MEMBER | | | |
| Street Address 35 SOUTH ANGELL 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 DONNA ZAKEN | | Manager Name | | | |
| Street Address 35 SOUTH ANGELL STREET | | Street Address | | | |
| City PROVIDENCE | State RI | Zip 02906 | 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

OCT 11 2013

File Date _____
 Check No _____ BY 1199
 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.

Donna Zaken
 Signature of Authorized Person _____ Date _____
DONNA ZAKEN, MEMBER
 Print or Type Name of Authorized Person