State of Rhode Island
and Providence Plantations
Department of State – Business Services Division

148 W. River Street
Providence, RI 02904-2615
401.222.3040

LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2019

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.	2. Exact name of the limited liability company	3. NAICS Code
001661409	SFD Holdings, LLC	531312

4. Brief description of the character of the business which is actually conducted in Rhode Island	5. State of Formation
real estate holding	Rhode Island

6. Principal office address	City	State	Zip
1002 Pawtucket Avenue	Rumford	RI	02916

7. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:

Contact Name	Contact Title
Justin W. Shaghalian, DMD	Manager

Street Address	City	State	Zip
1002 Pawtucket Avenue	Rumford	RI	02916

8. 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	Street Address	City	State	Zip
Justin W. Shaghalian, DMD	1002 Pawtucket Avenue	Rumford	RI	02916

Manager Name	Street Address	City	State	Zip

9. 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. 7-16-11Orson and Brusini Ltd.

FILED
SEP 30 2019
1016

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

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* 9/19/19

Justin W. Shaghalian, DMD, Manager

Print or Type Name of Authorized Person

File Date _____

Check No. _____

By: _____

FOR SECRETARY OF STATE USE ONLY