

Department of State - Business Services Division

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| R.I. DEPT. OF ST. | |
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2020 OCT 27 A IC

Annual Report for the year: 2020 Limited Liability Company

→ Filing period: September 1 - November 1

→ Filing Fee: \$50.00

→ Penalty: Additional \$25.00 fee if form is not filed by December 1.

| | | | | | | | | |
|--|---|---|--------------------------------|------------------|-----------|--|--|--|
| 1. Entity ID Number | | | Liability Company | | | | | |
| 268176 | NEI | NEW England Health and Willness LLC | | | | | | |
| 3. NAICS Code | 4. Brief descr | 4. Brief description of the character of business conducted in Rhode Island | | | | | | |
| 621399 | He | Health e Wellness & BIO Med. Survices | | | | | | |
| 5. State of Formation | and research & de colyment and Solutions | | | | | | | |
| 6. Principal Office Address | rincipal Office Address | | | State | Zip | | | |
| 176 arnold auc | | | Ganston | RI | 02905 | | | |
| 7. Mailing Address of Limited Liability Company and Name or Title of Contact Person | | | | | | | | |
| Contact Name John Eimig linecio | | | Contact Title MANAGING | MANAGING Partner | | | | |
| Street Address Come | | | City Cranston | State R/ | Zip 02905 | | | |
| | nd addresses) (| of the Limited Li | ability Company, IF APPLICABLE | - DO NOT LIST | MEMBERS | | | |
| Manager Name | | | Manager Name | Manager Name | | | | |
| Street Address | | | Street Address | Street Address | | | | |
| City | State | Zip | City | State | Zip | | | |
| Manager Name | | | Manager Name | | | | | |
| Street Address | | | Street Address | Street Address | | | | |
| City | State | Zıp | City | State | Zip | | | |
| Check the box to indicate an attachment | | | | | | | | |
| 9. The Resident Agent information | 9. The Resident Agent information currently of record with the RI Department of State is accurate. Changes require filing Form 642. | | | | | | | |
| 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. | | | | | | | | |
| Name of Authorized Person Date | | | | | | | | |
| Signature of Authorized Person The G. Myhen: | | | | | | | | |
| Signature of Authorized Person | | | | | | | | |
| pihag. W | pina. Myhen. | | | | | | | |

MAIL TO:

Division of Business Services

148 W. River Street, Providence, Rhode Island 02904-2615

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