




State of Rhode Island  
Department of State - Business Services Division

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Annual Report for the year: 2024  
Limited Liability Company

- Filing period: February 1 - May 1  
→ Filing Fee: \$50.00  
→ Penalty: Additional \$25.00 fee if form is not filed by May 31.

|                                                                                                                                                                                                             |  |                                                                                                                   |                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. Entity ID Number<br><b>000585705</b>                                                                                                                                                                     |  | 2. Exact name of the Limited Liability Company<br><b>CGHE Holdings , LLC</b>                                      |                                           |
| 3. NAICS Code<br><b>531190</b>                                                                                                                                                                              |  | 4. Brief description of the character of business conducted in Rhode Island<br><b>real estate holding company</b> |                                           |
| 5. State of Formation<br><b>RI</b>                                                                                                                                                                          |  |                                                                                                                   |                                           |
| 6. Principal Office Address<br><b>1196 Smith Street</b>                                                                                                                                                     |  | City<br><b>Providence</b>                                                                                         | State<br><b>RI</b><br>Zip<br><b>02908</b> |
| 7. Mailing Address of Limited Liability Company and Name or Title of Contact Person                                                                                                                         |  |                                                                                                                   |                                           |
| Contact Name<br><b>Kristofer Haggarty, DMD</b>                                                                                                                                                              |  | Contact Title<br><b>Manager</b>                                                                                   |                                           |
| Street Address<br><b>1196 Smith Street</b>                                                                                                                                                                  |  | City<br><b>Providence</b>                                                                                         | State<br><b>RI</b><br>Zip<br><b>02908</b> |
| 8. The Resident Agent information currently of record with the RI Department of State is accurate. Changes require filing Form 642.                                                                         |  |                                                                                                                   |                                           |
| <i>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.</i> |  |                                                                                                                   |                                           |
| Name of Authorized Person<br><b>Kristofer Haggarty, DMD</b>                                                                                                                                                 |  | Date<br><b>2/24/24</b>                                                                                            |                                           |
| Signature of Authorized Person<br>                                                                                       |  |                                                                                                                   |                                           |

MAIL TO:  
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