

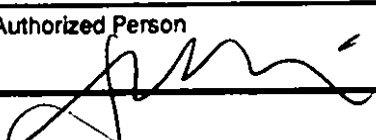


State of Rhode Island  
Department of State - Business Services Division

REC'D RIDOS BSD  
25 AUG 19 AM 11:57:09

Annual Report for the year: 2021  
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><u>001702371</u>                                                                                                                                                                 |  | 2. Exact name of the Limited Liability Company<br><u>ZEN DEN - NEWPORT LLC</u>                                                                                                                                                               |                    |
| 3. NAICS Code<br><u>812199</u>                                                                                                                                                                          |  | 4. Brief description of the character of business conducted in Rhode Island <u>Therapeutic services</u><br><u>1:1 services in PAIN MGMT, CRANIOSACRAL THERAPY,</u><br><u>YOGA, RED LIGHT THERAPY, AND OTHER HOLISTIC</u><br><u>services.</u> |                    |
| 5. State of Formation<br><u>Rhode Island</u>                                                                                                                                                            |  |                                                                                                                                                                                                                                              |                    |
| 6. Principal Office Address<br><u>42 SPRING STREET, SUITE 8A</u>                                                                                                                                        |  | City<br><u>NEWPORT</u>                                                                                                                                                                                                                       | State<br><u>RI</u> |
|                                                                                                                                                                                                         |  | Zip<br><u>02840</u>                                                                                                                                                                                                                          |                    |
| 7. Mailing Address of Limited Liability Company and Name or Title of Contact Person                                                                                                                     |  |                                                                                                                                                                                                                                              |                    |
| Contact Name<br><u>JULIA M. COLLINS</u>                                                                                                                                                                 |  | Contact Title<br><u>OWNER</u>                                                                                                                                                                                                                |                    |
| Street Address<br><u>20 BORDEN LANE</u>                                                                                                                                                                 |  | City<br><u>TIVERTON</u>                                                                                                                                                                                                                      | State<br><u>RI</u> |
|                                                                                                                                                                                                         |  | Zip<br><u>02878</u>                                                                                                                                                                                                                          |                    |
| 8. The Resident Agent information currently of record with the RI Department of State is accurate. Changes require filing Form 642.                                                                     |  |                                                                                                                                                                                                                                              |                    |
| 9. 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<br><u>JULIA M. COLLINS</u>                                                                                                                                                    |  | Date<br><u>8/19/2025</u>                                                                                                                                                                                                                     |                    |
| Signature of Authorized Person<br>                                                                                   |  |                                                                                                                                                                                                                                              |                    |

FILED

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MAIL TO:

Division of Business Services  
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