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STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPIESELV

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ABORTION FACILITIES LICENSE APPLICATION

OTHER (Specify)

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IUI	30	2010	HOSPITAL

WEALTH STANDARDS

	LICENSE NU	MBER C	77	EXPIRATION DATE	8 31	12010	
	TOTAL FEE AMOU	NT INCLUDED	# 600 00	CHECK/MONEY ORDER#	763	35	
TOTAL FEE AMOUNT INCLUDED LOCO CHECK/MONEY ORDER # 7635 Check if any change has occurred since last application. I. FACILITY (DBA) NAME Delto, Clinic of Baton Rouge, INC. GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste B CITY/STATE/ZIP Baton Rouge, LA 7080Le TELEPHONE NUMBER 225 923-3242 FAX NUMBER 225 924-4465							
	G ADDRESS (IF DIFF			Above			
III. ADMINIS	TRATOR 5 YV NURSE:	ia Cac	hran Physician ass	MEDICAL DIRECTOR:	Dr.M	ary F. Natasha	Gardner Seymon
IV. TYPE O	F OWNERSHIP:						
	NON- PI	ROFIT		FC	DR - PROFI	Т	
☐ CORPORA ☐ PARTNER ☐ RELIGIOU	RSHIP IS AFFILIATION PORATED ASSOCIAT			INDIVIDUAL / SOLE CORPORATION PARTNERSHIP GROUP PRACTICE OTHER (Specify)			
N. ENTITY/CORPORATION NAME Delta Clinic of Baton Kouge. Inc. MAILING ADDRESS (IF DIFFERENT) 7510. Colonial Drive Ste B CITY/STATE/ZIP Baton Rouge, LA 70806 TELEPHONE NUMBER 225 923-3342 FAX NUMBER 225 924-4465 VII. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (\$5\%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity (ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).							
(192)	NED NAME	7		ADDRECC		TELEPHO	DNE #

ADDRESS

OWNER NAME

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporati	tion, list name, address and telephone number of the President.	
NAME	ADDRESS	TELEPHONE NUMBER
Leroy T. Brinkley	8602 Thomas Mill Roll ahilas	215482-3764
	tity also owners of other licensed health care facilities? Member). If yes, list names, addresses of individuals and Facility p	YES INO provider numbers.
NAME	ADDRESS	PROVIDER NUMBER
Pansu M. Myre	1704 N. Park Dr. # 310	Women's Health Care CtR
	Wilmington, DE 19804	Lic #3
	ATION: - Friday HOURS OF OPERATION 9A	m - 5pm
t is my responsibility to notify the Depart riting of any changes in the information	agency license is granted, it is granted for one year and shall bed tment of Health and Hospitals, Bureau of Health Services Find provided in this application. I certify that the information here, we. Documentation of the information above is available upon to - My e5 AME (TYPED OR PRINTED)	ancing, Health Standards Section in ein is true, correct and supportable by



STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS



ABORTION FACILITIES JUL 2 9 2009 LICENSE APPLICATION

HEALTH STANDARDS

LICENSE NUME	BER OT	EXPIRATION DATE 831 CHECK MONEY ORDER # 777	1200		
check if any change has occurred. I. FACILITY (DBA) NAME DE GEOGRAPHICAL ADDRESS T CITY/STATE/ZIP	ed since last application Elta Clinic of 56 Colonial Xaton Rouge	STATE ID# ABOUT Botton Rouge, In Drive Ste B	1 <i>C</i>		
II. MAILING ADDRESS (IF DIFFER CITY/STATE/ZIP	ENT FROM ABOVE)	ne as above	-		
REGISTERED NURSE: NO	Horpsoul Horpsoul				
IV. TYPE OF OWNERSHIP:	APIT.	POP PROFIL			
NON- PROFIT INDIVIDUAL/SOLE PROPRIETOR CORPORATION PARTNERSHIP RELIGIOUS AFFILIATION UNINCORPORATED ASSOCIATION OTHER (Specify): OTHER (Specify):					
N. ENTITY/CORPORATION NAME Delta Cinic of Baton Rouge, Inc. MAILING ADDRESS (IF DIFFERENT) 754 Colonial Drive Ste B CITY/STATE/ZIP Boton Rouge, La 70804 TELEPHONE NUMBER 225923-3243 FAX NUMBER 2259924-444€ WII. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity (ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).					
OWNER NAME ADDRESS TELEPHONE # Pansy Myrie 1704 N: Park Drive, #310 Wilminaton, DE 19804					

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporat	tion, list name, address and telephone number of the President.	
	ADDRESS 8602 Thomas Mill Road Philadelphia, PA 19128 tity also owners of other licensed health care facilities? Member). If yes, list names, addresses of individuals and Facility prov	
Pansy M. Myre	Milmington, DE 19804	PROVIDER NUMBER Women'S Health Care (
X. Has there been a change of ownership If yes, give date. PROCED AN OPER ATION AND INCOME.		N.O. LA Licto
A. PROGRAM OPERATIONAL INFORM DAYS OF OPERATION MON — First of the control of th		F 9 00a - 5p 73g-5p
t is my responsibility to notify the Depar riting of any changes in the information	agency license is granted, it is granted for one year and shall become timent of Health and Hospitals, Bureau of Health Services Finance provided in this application. I certify that the information herein ge. Documentation of the information above is available upon required.	cing, Health Standards Section is
AUTHORIZED REPRESENTATIVE	7/11/2009	7

JUL 2 9 2009 HEALTH STANDARDS

DATE



RECEIVED ATE OF LOUISIANA DEBARTMENT OF HEALTH AND HOSPITALS

AUGDENATURE OF HEALTH and HEALTH STANDARDS

LOUISIANA

HEALT MANDEULATORY SURGICAL CENTER
LICENSE APPLICATION

	LICENSE APPLICATION	
INITIAL X	RENEWAL OTHER (Specify) STATE STATE	08
LICENSE NUMBER		
TOTAL FEE AMOUNT INCLU		
CITY/STATE/ZIP Check if any change has occurred since last the control of the co	Colonial Drive Ste B Rouge, LA 70806	oc.
II. MAILING ADDRESS (IF DIFFERENT FROM	1 ABOVE)	
CITY/STATE/ZIP	Same as above	
CIIT/SIAIE/ZII		M (/ / / / / / / / / / / / / / / / / /
II. ADMINISTRATOR SYLVIO A	. Cochrah DIRECTOR OF NURSING: DI	Mary F Gar
V. LOCATION: ———————————————————————————————————	D □ FREE STANDING	
7. TYPE OF OWNERSHIP: JON- PROFIT	FOR - PROFIT GC	OVERNMENT
INDIVIDUAL/SOLE PROPRIETOR	☐ INDIVIDUAL/SOLE PROPRIETOR ☐ FEDERAL	☐ HOSPITAL DISTRICT
	☐ CORPORATION ☐ STATE	COMBINATION GOV-N-PROFIT
CORPORATION	☐ PARTNERSHIP ☐ PARISH	OTHER Specify)
J PARTNERSHIP	GROUP PRACTICE CITY / PARISH	
RELIGIOUS AFFILIATION		
UNINCORPORATED ASSOCIATION	OTHER (Specify)	
OTHER (Specify):	to Clinic of Baton Rou	ge, INC.
VI. ENTITY/CORPORATION NAME DE	ACI CITIE O	
MAILING ADDRESS (IF DIFFERENT) 150	7010	
CITY/STATE/ZIP Botton	Rouge LA 70801	11117
TELEPHONE NUMBER (225 012	3-3242 FAX NUMBER (225 124	-4405
VII. List name, address, and Telephone numbers for person	ns or group of persons, or the employer identification number (EIN) for organizate thership interest or any person or business entity which has a direct business into the benefit of any party and whether such stock, partnership into other person or business entity (ATTACH ADDITIONAL SHEETS IF ADDITIONA	rect or ownership being held by the
OWNER NAME	ADDRESS	EIN
Pansy Myrie	1704 N. Park Drive # 310	161-62-9745
Transf	Wilminaton DF 19806	

ABORTION FACILITIES LICENSE APPLICATION

ABORTION FACILITIES LICENSE APPLICATION
VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.
IVAME
SUCCE Thomas MILL POSICE TELEPHONE NUMBER
philadelphia PA 19128 215-482-37611
VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? (Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers. NAME.
ADDRESS
ansy M. Mure 1704 N Park # 310
Wilmington, DE 19804 Center Tix
Has there been a change of ownership or control within the last year? When or least year? Were the seen a change of ownership or control within the last year? When or least year?
PROGRAM OPERATIONAL INFORMATION: AYS OF OPERATION MONDOW - Fridowy Hours of OPERATION APP - 5PM this a change since last application? YES ANO
TESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of the person of the properties of the provided in this application. I certify that the information herein is true, correct and content of Health and Hospitals. I certify that the information herein is true, correct and content of Health and Hospitals.
BEHU HOUVELL - Myles THORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)
AUTHORIZED REPRESENTATIVE SIGNATURE
DATE

Please Send current Fire + Health Inspection Report.



STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS



ABORTION FACILITIES

LICENSE APPLICATION

Department of HEALTH and HOSPITALS

INITIAL VRENEWAL OTHER (Special	y) e ^x				
LICENSE NUMBER	EXPIRATION DATE 8/3//07				
TOTAL FEE AMOUNT INCLUDED \$ 600	THECK MONEY ORDER # 5701				
CITY/STATE/ZIP Theck if any change has pocurred since last application of Baton Rouge, INC., STATE ID#AB000 46 42 INC., GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste. B CITY/STATE/ZIP Baton Rouge, LA 70806 TELEPHONE NUMBER 225 923-3242 FAX NUMBER 225 924-4465 II. MAILING ADDRESS (IF DIFFERENT PROM ABOVE) CITY/STATE/ZIP COMU					
II. ADMINISTRATOR	MEDICAL DIRECTOR:				
TERED NURSE PHYSICIAN ASSIS	TANT: LPN:				
. TYPE OF OWNERSHIP:					
NON- PROFIT	FOR - PROFIT				
☐ INDIVIDUAL/SOLE PROPRIETOR ☐ CORPORATION ☐ PARTNERSHIP	INDIVIDUAL/SOLE PROPRIETOR CORPORATION PARTNERSHIP				
RELIGIOUS AFFILIATION	GROUP PRACTICE				
JUNINCORPORATED ASSOCIATION	OTHER (Specify)				
JOTHER (Specify):	UTHER (Specify)				
M. ENTITY/CORPORATION NAME Delta Ciruc of Boton Rouge, Inc.					
TTY/STATE/ZIP					
ELEPHONE NUMBER () FAX NUMBER ()					
I. List name, address, and Telephone numbers for persons or group of persons, or the employer identification number (EIN) for organizations having direct or direct ownership or a controlling interest (2.5%) of the corporate stock or partnership interest or any person or business entity which has a direct business terest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether the stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity TTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).					
OWNER NAME	ADDRESS EIN ,				
Junsy Myrie 1704 N.	ork (Drive #310 161-62-9745				
() Ulingingto	1. DE 19800				

STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS BUREAU OF HEALTH SERVICES FINANCING HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporation, l	ist name, address and telephone number of the President.	
Lerou T. Brinkfell	8002 Thomas Mill Road (31)	TELEPHONE NUMBER
	Philadelphia Pa 19128 YES ber). If yes, list names, addresses of individuals and Facility provide	INO or numbers.
NAME	ADDRESS	PROVIDER NUMBER
Yansy M. Myre	1704 N. Park Drive #310	Women's Healt
	Wilmington, De 19806	Care Center
IX. Has there been a change of ownership or con If yes, give date.	ntrol within the last year? TYES NO	New Orleans, I.
X. PROGRAM OPERATIONAL INFORMATION OAYS OF OPERATION MODICAL s this a change since last application? YE	ricky HOURS OF OPERATION 9:50 A	n-5:00 PM
ection in writing of any changes in the inform	ency license is granted, it is granted for one year and shall appartment of Health and Hospitals, Bureau of Health Services attion provided in this application. I certify that the information y knowledge. Documentation of the information above is a	Financing, Health Standards
Betty Harrell-Myles UTHORIZED REPRESENTATIVE NAME	(TYPED OR PRINTED)	
AUTHORIZED REPRESENTATIVE SIG	GNATURE 7/25/2007	veg nemeska a nom



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STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS



Department of s

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tarre a		ENSE APPLICATION	4.7
INITIAL	_ 4_	HER (Specify)	
LICENSE	NUMBER D7	EXPIRATION DATE 8-	31-06
TOTAL FEE AM	MOUNT INCLUDED \$ 600	2 CHECK MONEY ORDER # 41-82	
Check if any change has	s permitted time the application		
I. FACILITY (DBA) NAME	Delta Clinico	Baton Rouge Inc	B000 4642
GEOGRAPHICAL ADDRES	5756 Colonias	Drive SAB	
CITY/STATE/ZIP	Daton Kouge	LA 70806	
TELEPHONE NUI	MBER 225 923-	3242 FAX NUMBER 25 9	24-4465
II. MAILING ADDRESS (IF	DIFFERENT FROM ABOVE)		
CITY/STATE/ZIP	Some		
I. ADMINISTRATOR)	the Ann Cochron	MEDICAL DISTARRANGE	16000
EGISTERED NURSE:	PHYPICIA	MEDICAL DIRECTOR MONTH	Frances Santre
YPE OF OWNERSHIP:	THISICIA	N ASSISTANT: L	PN:
NON	- PROFIT	FOR - PRO) FIF
INDIVIDUAL / SOLE PRO	OPPIETOR		44,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
7 CORPORATION	MALION	INDIVIDUAL/SOLE PROPRIE	TOR
7 PARTNERSHIP		CORPORATION	
7 RELIGIOUS AFFILIATION	*	PARTNERSHIP	
_		GROUP PRACTICE	
UNINCORPORATED ASSOC	IATION	OTHER (Specify)	
JOTHER (Specify):	N.		-
. ENTITY/CORPORATION NAM	AE DEHA Clinic	of Buton Rouge In	
SILING ADDRESS (IF DIFFERENT	SAME as	above	
TY/STATE/ZIP			
LEPHONE NUMBER		FAX NUMBER ()	
rest, including, but not limited to a	wholly owned subsidiary, the deta	persons, or the employer identification number (EIN) to ock or partnership interest or any person or business en alls of any conversion rights which may exist for the ben person or business entity is, in fact, owned by another o).	tity which has a direct business
OWNER NAME		ADDRESS	
a . MI MA	1121		EIN

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DEPARTMENT OF HEALTH AND HOSPITALS

HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

		The state of the s	
VII. If the disclosing entity is a corporation, lis	name, address and telephone n	umber of the President.	
NAME	ADI	DRESS ?	TELEPHONE NUMBER
Leroy 7. Brinkley	8602 Thomas 1	Will Road	215 482-3764
VIII. Are any owners of the disclosing entity all (Proprietorship, Partnership or Board Memi	o buners of other licensed health	a care facilities?	yės Dno
O NAME			
Pancy M. M. Vice	17 ALL ALL	RESS	PROVIDER NUMBER
ansy in myrie	Dilminaton	De 19001-) Cyomen's Hearth
,	Diffing tony	21100	Cure Corner
X. Has there been a change of ownership or con	trol within the last year?	I YES YONO	Mas Greans, LA
If yes, give date.			ALC #3
A PROGRAM OPERATIONAL INFORMATION OAYS OF OPERATION MONDAY - 1 sthis a change since last application? TES	Tickey HOURS	OF OPERATION 9:00	1 Abr - 5:00 PM
TTESTATION: I understand that if the age rship. It is my responsibility to notify the D non in writing of any changes in the inform. Importable by documentation to the best of n epartment of Health and Hospitals.	opin anent of steath and Hosp ation provided in this applicat ty knowledge. Documentatio	uais, Bureau of Health Se	rvices Financing, Heulth Standard
Dy Wa Hon Cochr	α_{λ}		
SUPILIA UN CINALIA	(TYPED OR PRINTED)	4/27/01	
AUTHORIZED REPRESENTATIVE SIG	<u>GNATURE</u>	DATE	

Please Send current Fire + Health Inspection Report.



STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS



ABORTION FACILITIES LICENSE APPLICATION

CORPORATION PARTNERSHIP RELIGIOUS AFFILIATION OTHER (Specify): ENTITY/CORPORATION NAME SO ME AS Above SULING ADDRESS (IF DIFFERENT) TY/STATE/ZIP CORPORATION OTHER CORPORATION OTHER (Specify) PARTNERSHIP OTHER (Specify) OTHER (Specify) PROPORATION OTHER (Specify) PROPORATION OTHER (Specify) PROPORATION OTHER (Specify) HEALTH STANDARDS	INITIAL _V RENEW/	L OTHER (Speci	ify)	
check if any change has occurred since last application FACILITY (BBA) NAME De Ha Clinic of Baten Rouge, Inc. FACILITY (BBA) NAME De Ha Clinic of Baten Rouge, Inc. GEOGRAPHICAL ADDRESS 756 Cc onic Drive Suite B CITY/STATE/ZIP Baten Rouge LA 70806 TELEPHONE NUMBER (225) 923-3242 TELEPHONE NUMBER (225) 923-3242 TAX NUMBER 225 924-4465 TI. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) CITY/STATE/ZIP DMINISTRATOR Sylvia A Cochran MEDICAL DIRECTOR: May Frances Gardener TYPE OF OWNERSHIP: NON-PROFIT FOR - PROFIT INDIVIDUAL/SOLE PROPRIETOR CORPORATION PARTNERSHIP RELIGIOUS AFFILIATION CORPORATION COTHER (Specify): ENTITY/CORPORATION NAME 50 Me As Above JUL & 2005 WILING ADDRESS OF DIFFERENT) FAX NUMBER (Specify): FAX NUMBER (Specify): LEPHONE NUMBER (Sylvia) of the corporate stock or partnership interest or any person or business entity which has a direct business real, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any partnership interest for any person or business entity which has a direct business real, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any parts and whether real, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any parts and whether real, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any parts and whether real, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any parts and whether real, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any parts and whether real, including the real to any person or business entity which has a direct business entity which has exist for the benefit of any parts and w			EXPIRATION DATE _ 8	-31-05
GEOGRAPHICAL ADDRESS 756 C. C. C. C. C. D. Y. V. S. L. F. B. CITY/STATE/ZIP BATON ROUGE, LA 70806 TELEPHONE NUMBER (223) 923-3242 FAX NUMBER 225, 924.4465 II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) CITY/STATE/ZIP DMINISTRATOR Sylvia A. Coch pan Medical directors: May Frances Gardiner, GISTERED NURSE: Physician assistant: LPN: TYPE OF OWNERSHIP: NON-PROFIT FOR - PROFIT INDIVIDUAL/SOLE PROPRIETOR CORPORATION PARTNERSHIP PRECIPIED RELIGIOUS AFFILIATION OTHER (Specify): GROUP PRACTICE UNINCORPORATION OTHER (Specify): ENTITY/CORPORATION NAME Some As Above RECEIVED LETTITY/CORPORATION NAME Some As Above RELIGIOUS AFFILIATION OTHER (Specify): HEALTH STANDARDS LETTITY/CORPORATION NAME Some As Above RELIGIOUS AFFILIATION OF THE STANDARDS LETTITY/CORPORATION NAME Some As Above RELIGIOUS AND STANDARD SOME STANDARD SOME SOME SOME SOME SOME SOME SOME SOME	TOTAL FEE AMOUNT INCLUD	ED 000.00	CHECK/MONEY ORDER# 3380).
TELEPHONE NUMBER (223) 923-3242 FAX NUMBER 225 924-4465 II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) CITY STATE / ZIP DMINISTRATOR Sylvia A. Coch ran MEDICAL DIRECTOR: May Frances Gardner (ISTANDER) GISTERED NURSE: PHYSICIAN ASSISTANT: LPN: TYPE OF OWNERSHIP: NON-PROFIT FOR - PROFIT INDIVIDUAL / SOLE PROPRIETOR CORPORATION PARTNERSHIP ARLIGIOUS AFFILIATION OTHER (Specify): ENTITY / CORPORATION NAME Solvie AS Above PARTNERSHIP LEPHONE NUMBER (. FACILITY (DBA) NAME De ta	Clinic of	Baron nouge, inc.	\$0004642
TELEPHONE NUMBER (225) 924.4465 II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) CITY STATE / ZIP DMINISTRATOR 5 VIO. A . Coch yam MEDICAL DIRECTOR: MANY Frances G. Ordiner GISTERED NURSE: PHYSICIAN ASSISTANT: LPN: TYPE OF OWNERSHIP: NON- PROFIT INDIVIDUAL / SOLE PROPRIETOR CORPORATION PARTNERSHIP RELIGIOUS AFFILLATION UNINCORPORATED ASSOCIATION OTHER (Specify): ENTITY / CORPORATION NAME 50 yme As Above DULING ADDRESS (IF DIFFERENT) TY / STATE / ZIP LEPHONE NUMBER (
CITY/STATE/ZIP DMINISTRATOR SYVIO A COCHYAM MEDICAL DIRECTOR: MAKE FRANCES GARDING. GISTERED NURSE: PHYSICIAN ASSISTANT: LPN: TYPE OF OWNERSHIP: NON- PROFIT INDIVIDUAL/SOLE PROPRIETOR CORPORATION PARTNERSHIP RELIGIOUS AFFILLATION OTHER (Specify): ENTITY/CORPORATION NAME SO YME AS A DEVE DILING ADDRESS (IF DIFFERENT) TY/STATE/ZIP LEPHONE NUMBER (DUTON	nouge, L	A 10806	
DMINISTRATOR SYNIA A. COCHYAM MEDICAL DIRECTOR: MAN FRANCES GAVIDARY GISTERED NURSE: PHYSICIAN ASSISTANT: LPN: TYPE OF OWNERSHIP: NON- PROFIT FOR - PROFIT INDIVIDUAL/SOLE PROPRIETOR CORPORATION PARTNERSHIP RELIGIOUS AFFILIATION OTHER (Specify): ENTITY/CORPORATION NAME SO YNE A DOVE FAX NUMBER (LIST name, address, and Telephone numbers for persons or group of persons, or the employer identification number (EIN) for organizations having direct or rest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may set for the benefit of any party and whether ock, partnership interest (a, a wholly owned subsidiary, the details of any conversion rights which may set for the benefit of any party and whether ock, partnership interest or ready person or business entity which has a direct business rest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may set for the benefit of any party and whether ock, partnership interest, or any person or business entity with the subsidiary, the details of any conversion rights which may set for the benefit of any party and whether ock, partnership interest, or any person or business entity is, in fact, owned by another person or business entity OWNER NAME ADDRESS EIN RECEIVED AT STANDARDS FAX NUMBER (JUL 2 2 2005 HEALTH STANDARDS FAX NUMBER (JUL 2 2 2005 HEALTH STANDARDS THE ACT OF THE ACT	TELEPHONE NUMBER (223	1 423-3242	FAX NUMBER 225	924.4465
DMINISTRATOR SYVIA A. COCHYAM MEDICAL DIRECTOR: MANY FRANCES GAYDNER GISTERED NURSE: PHYSICIAN ASSISTANT: LPN: TYPE OF OWNERSHIP: NON-PROFIT FOR - PROFIT INDIVIDUAL/SOLE PROPRIETOR CORPORATION PARTNERSHIP RELIGIOUS AFFILIATION OTHER (Specify): ENTITY/CORPORATION NAME SO YNE AS A DO VE UNINCORPORATION NAME SO YNE AS A DO VE SULING ADDRESS (IF DIFFERENT) LIST NAME LIST NAME LIST NAME LIST NAME OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED). OWNER NAME ADDRESS ENTITY OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OUT TO THE COCHY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED. OWNER NAME ADDRESS ENTITY SA DO TIONAL SPACE IS NEEDED.	II. MAILING ADDRESS (IF DIFFERENT FRO	M ABOVE)		
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STAIR OF LOUISIANA DEPARTMENT OF MEASURE AND DESIGNALS

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ABORTION FACILITIES LICENSE APPLICATION

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VIII. Are any owners of the d (Proprietorship, Parmersh	ixclosing entity also owners of oth ip or Bourd Member). If yes, list	ner licensed health cure facilities? names, addresses of individuals a	X YES	DNO roumbers.
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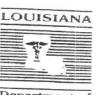
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ELEPHONE NUMBER (

STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

ABORTION FACILITIES



Department of HEALTH and HOSPITALS

	APPLICATION
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LICENSE NUMBER	EXPIRATION DATE
TOTAL FEE AMOUNT INCLUDED 600	CHECK/MONEY ORDER # 2648
check if any change has occurred since last application. I. FACILITY (DBA) NAME DELLA (INICAL BOGEOGRAPHICAL ADDRESS 756 SOUNGS IN CITY/STATE/ZIP TELEPHONE NUMBER 225 923-324.	STATE ID# ABOOD CHON ROUGE, INC DRIVE STEB 7 70806 2 FAX NUMBER 225 924-4465
II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	
CITY/STATE/ZIP	
II. ADMINISTRATOR SULVIN Ann Cochran	MEDICAL DIRECTOR Mary Frances Gardne
ECICTEDED MIDOS	MAN MAN
V. TYPE OF OWNERSHIP: PHYSICIAN ASSIS	LPN: LPN:
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FAX NUMBER (___

OWNER NAME	ADDRESS	EIN
eroy T. Brinkley	2809 Baynard Blvd	180-30-1304
OFFICE OF MANAGEMENT AND	Wilmington, De 19802	302 888-1102

ABORTION FACILITIES LICENSE APPLICATION

. If the disclosing entity is a corporation,	list name, address and telephone number of the President.	
NAME	ADDRESS	TELEPHONE NUMBER
II. Are any owners of the disclosing entity (Proprietorship, Partnership or Board Mo	also owners of other licensed health care facilities? YES rember). If yes, list names, addresses of individuals and Facility provid	□NO er numbers.
NAME	ADDRESS	PROVIDER NUMBER
eroy T. Brinkley	2809 Baynard Blvd-WilmDE	03
omen's Health Care Cen	the 2701 General Pershing Street	
PROGRAM OPERATIONAL INFORMATION OF OPERATION MONDAY - Substitution ?		Telephones a hours
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ership. It is my responsibility to notify to ion in writing of any changes in the inf portable by documentation to the best	he Department of Health and Hospitals, Bureau of Health Service formation provided in this application. I certify that the information of my knowledge. Documentation of the information above is	es Financing, Health Stand tion herein is true, correct
artment of Health and Hospitals.	iran	
Sulvia Am Cock	() (A) (ME (TYPED OR PRINTED)	

State of Monigiana Department of Health and Hospitals

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ertify that	Delta Clinic of Baton Rouge, Inc.
is hereby duly licensed to operate	Delta Clinic of Baton Rouge, Inc.
	756 Colonial Drive Suite B
	Baton Rouge, LA 70806
with a licensed capacity of	

or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining , but may be revoked thereto. This license is not transferable and must be renewed annually. 08/31/2011 This license shall expire on

08/31/2010

Date of Issue

State of Mouisiana Department of Health and Hospitals

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This is to certify that Delta Clinic of Baton Rouge, Inc. is hereby duly licensed to operate Delta Clinic of Baton Rouge, Inc.	756 Colonial Drive Suite B Baton Rouge, LA 70806	This license shall expire on $08/31/2010$ or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

Director

08/21/2009 Date of Issue

Department of Health and Hospitals State of Amisiana

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at

08/22/2008 Date of Issue

Department of Health and Hospitals State of Amisiana

LICENSE

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at

08/20/2007

Date of Issue

State of Mouisiana Department of Health and Hospitals

LICENSE

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This license shall expire on

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Date of Issue

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State of Monigiana Department of Health and Hospitals

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	Baton Rouge, LA 70806	1
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08/22/2005

Date of Issue

State of Muniziana Department of Health and Hospitals

LICENSE

Delta Clinic of Baton Rouge, Inc. ABORTION CLINIC	756 Colonial Drive	Baton Rouge, LA 70806	N/A
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09/28/2004

Date of Issue





Department of Health and Hospitals
Bureau of Health Services Financing

February 1, 2010

Certified Mail Return Receipt Requested # 7007 2680 0000 8113 6342

Sylvia Cochran, Administrator Delta Clinic Of Baton Rouge, Inc 756 Colonial Drive Baton Rouge, LA 70806

Re:

Survey 12/07/2009 Plan of Correction

Dear Ms. Cochran:

This letter acknowledges receipt of your facility's plan of correction for deficiencies cited during the licensing survey of December 7, 2009. The Plan of Correction (PoC) submitted by your facility is not acceptable and will require the following revisions before it can be considered acceptable by this Department:

Tag S4405 -The PoC for items #1 and #2 indicates that the facility will collect data at different intervals during the year, but corrective action will only be addressed annually when submitted to the governing body. Additionally, item # 1 has an effective date of 12/12/09, but the completion date listed is 12/08/09.

Tag S4409 & S4411 - The PoC for these tags indicates that the office manager will be responsible for implementing the PoC for a period of one year. How will the facility ensure that the PoC continues to be followed and ensure that compliance is sustained?

Tag S4415 - The PoC for item #1 indicates that "Delta Clinic acknowledges that information concerning its patient records managed to reach the Public by way of the Louisiana Department of Health and Hospitals." This is an incorrect statement. The Louisiana Department of Health and Hospitals **did not** release or make public any Delta Clinic's patient records in any manner. Please delete this statement from the PoC.

Page 2 Sylvia Cochran February 1, 2010

Tag S4419 - The PoC for item #2 indicates that the facility will mix a solution of Cavacide and water. However, it is not clear that the solution mixture is compliant with the manufacturer's suggested guidelines. Please submit a copy of the manufacturer's guidelines and documentation that the solution mixture to be used is compliant with the requirements.

Tag S4421 - The PoC for item #3 indicates that the physician's standing orders are dated and signed by the physicians as being approved, but the PoC does not address how the facility will ensure the physician's standing orders will be timed, dated and signed by the physician and made specific for each patient and entered into each patient's chart. An approval as to whether or not the physician's standing orders submitted with this PoC were acceptable was not made. This tag was cited for the facility's failure to ensure that the physician's standing orders were timed, dated, and signed by the physician.

Please address the above mentioned item(s) by placing the amended plan of correction on the <u>enclosed original statement of deficiency report form.</u> Should you need additional space, you may use additional blank pages referencing each Tag number followed by the revised plan of correction. The original deficiency report form and the amended plan of correction must be returned to this office no later than 24 hours after receipt. Please advise this office if you will not be able to meet this deadline. I have also enclosed the "5 components" for an acceptable Plan of Correction which must be included in the revised plan of correction.

If you have any questions, please contact me at 225-342-6096.

Sincerely,

Dora Kane, R.N. Non-Long Term Care Supervisor

Enclosure



Department of Health and Hospitals Bureau of Health Services Financing

IMPORTANT NOTICE-PLEASE READ CAREFULLY

DATE:

02/08/2011

TO:

ADMINISTRATOR Delta Clinic Of Baton Rouge, Inc.

FROM:

HEALTH STANDARDS SECTION

RE:

ANNUAL LICENSING SURVEY RESULTS

On February 3, 2011, a survey was conducted at your facility by the Department of Health and Hospitals, Health Standards Section, to determine if your facility was in compliance with licensing standards established by the State of Louisiana. This survey found deficiencies in your facility whereby corrections are required to assure compliance with licensing standards.

Enclosed for your completion and prompt response is the <u>STATE FORM</u> (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (PoC)). A PoC for the deficiencies must be submitted within 10 working days after your receipt of the STATE FORM. In the column "Completion Date," enter a projected date of correction. An explicit date must be shown. This date may not exceed 60 days from the completion of the survey. Please refer to the enclosed memorandum, <u>Required Components for the Plan of Correction</u>, for guidance in developing your PoC. Failure to submit an acceptable PoC by the date indicated below may result in the imposition of specified remedies. The STATE FORM must be signed and dated by the administrator or other authorized official as indicated. The <u>SIGNIFICANT FINDINGS</u> form, if enclosed, does not require a PoC, but the facility is expected to sign, date, and return the form.

You have one opportunity to question citations of deficient practice through an Informal Dispute Resolution process. To be given such an opportunity you must send your written request, specifying the deficient practice(s) that you are disputing and why you are questioning these, to: DHH/Health Standards Section, Attention IDR Program Manager, P.O. Box 3767, Baton Rouge, LA 70821-3767. The request must be made within 10 days of receipt of your STATE FORM. Again, this is an informal dispute resolution and it is not necessary for your attorney to be present, however, if you wish for your attorney to be included in the informal dispute resolution, please advise this office. Please refer to the enclosed memorandum, Informal Dispute Resolution Process, for further information.

Please provide this PoC by February 21, 2011. Mail the completed original and properly signed/dated PoC to: Health Standards Section, Attention Program Manager, P.O. Box 3767, Baton Rouge, Louisiana 70821-3767.



Department of Health and Hospitals Bureau of Health Services Financing

02/22/2011

Ms. Sylvia A. Cochran, Administrator Delta Clinic Of Baton Rouge, Inc 756 Colonial Drive Baton Rouge, LA 70806

Dear Ms. Cochran:

This letter acknowledges receipt of your facility's plan of correction for deficiencies cited during the licensing survey of February 3, 2011. The plan of correction submitted by your facility is not acceptable and will require the following revisions before it can be considered acceptable by this Department:

1. Tags S4405 and S4415: The plan of correction must specify that prior to an abortion procedure being performed the M.D. shall ensure that proper consents and reporting requirments have been met.

Please address the above mentioned item(s) by placing the amended plan of correction on a seperate sheet of paper. Please identify the tag numbers for each revision made to the revised Plan of Correction. Please fax the revisions no later than 24 hours after receipt to 225-342-0157. If you have any questions, please contact me at 225-342-2205.

Sincerely,

Christopher Vincent, RN, BSN Medical Certification Program Manager Abortion Facilities, ASCs, and Hospitals



Department of Health and Hospitals Bureau of Health Services Financing

January 20, 2010

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
7007 2680 0000 8114 3043

Attn: Ms. Sylvia A. Cochran Delta Clinic of Baton Rouge, Inc. 756 Colonial Drive Baton Rouge, LA 70806

RE:

Delta Clinic Of Baton Rouge, Inc

ID:N/A

Medicaid ID:N/A

State ID: BO0004642

Dear Ms. Cochran:

On 12/07/2009, a licensure survey and a survey on complaint #9AB28180 were conducted at the above referenced facility. At that time it was determined that the facility was out of compliance with the federal and/or state rules for hospitals. Specifically, the facility had deficient practices, including Immediate Jeopardy, in the following areas:

St - S - 4409 - - Personnel

St - S - 4419 - - Infection Control

St - S - 4421 - - Pharmaceutical Services

This office has determined that your facility's failure to comply with these rules constitutes separate Class "B" violations pursuant to a final rule published by this Department in July of 2000, in that the above referenced facility's actions or inactions created the substantial probability that serious harm or death would result to a patient(s) if the situation was not corrected. As a result of these infractions, we are assessing this facility a Civil Fine of \$1,400.00 for the violations under Tag S-4409, a Civil Fine of \$800.00 for the violations under Tag S-4419, and a Civil Fine of \$800.00 for the violations under Tag S-4421, for these Class "B" violations, as referenced in this letter.

Therefore, the total amount of the Civil Fines assessed against this facility for these separate Class "B" violations, as referenced in this letter, is \$3,000.00.

Further details of these violations are included in the 12/07/2009 survey statement of deficiencies, "State Form" (previously received by this facility) which are

incorporated by reference herein.

You may request an **Informal Reconsideration** of this decision to impose a civil fine. The request for Informal Reconsideration must be in writing and must be forwarded to the following address:

IDR Program Manager BHSF, Health Standards Section P. O. Box 3767 Baton Rouge, LA 70821-3767

Your request for Informal Reconsideration must be received by this office within ten (10) days from receipt of this notice letter and must include any documentation that you think demonstrates this determination was made in error. If a timely request for the Informal Reconsideration is received by this office, an Informal Reconsideration will be scheduled and you will be notified of the time and place. The reconsideration decision shall be based upon all documentation and oral testimony furnished by the provider to the department at the time of the Informal Reconsideration.

You also have the right to an **Administrative Appeal** regarding this decision. If you desire to appeal the proposed civil fine, you must file a written request within thirty (30) days after receipt of this notice letter. Your request for an Administrative Appeal must be forwarded to the following:

Department of Health and Hospitals Bureau of Appeals Post Office Box 4183 Baton Rouge, LA 70821-4183

The Bureau of Appeals will require a party requesting an appeal to (1) post an appeal bond with the Bureau of Appeals as provided in La. R.S. 40:2199(D), or (2) file a devolutive appeal wherein the facility pays the civil fine pending the outcome of the appeal.

The Department's decision to impose the civil fine becomes final and no administrative or judicial relief may be obtained if you fail to timely request an Informal Reconsideration and/or Administrative Appeal.

Please note that the request for an Informal Reconsideration does not constitute a request for an Administrative Appeal, nor does it extend the time limit for requesting an Administrative Appeal.

Also, please note that if you do not request an Administrative Reconsideration or an Administrative Appeal, this letter constitutes notice of this Department's <u>final</u> decision to impose a sanction. Once the delays for filing for an Administrative Reconsideration and/or Administrative Appeal have run, the decision to impose this Civil Fine becomes final and you must remit your payment within ten (10) days to:

La. Department of Health and Hospitals ATTN: James Taylor, Sanction Desk Post Office Box 3767 Baton Rouge, LA 70821-3767

Upon remittance, clearly indicate that the check is for payment of a civil monetary penalty.

If you have any questions regarding this letter, please contact James H. Taylor, III at (225) 342-5457.

Sincerely, BHSF,HealthStandards Section

Erin Rabalais, RN

Section Chief

ERIJHT

cc: File Copy
Hospital Program Desk
Ivory Trent, Bureau of Appeals
Mike Chapman, Financial Management



Department of Health and Hospitals Bureau of Health Services Financing

February 25, 2011

CERTIFIED MAIL RETURN RECEIPT REQUESTED # 7007 2680 0000 8269 1413

Delta Clinic of Baton Rouge, Inc. Attn: Ms. Sylvia A. Cochran, Administrator 756 Colonial Drive Baton Rouge, LA 70806

RE: Delta Clinic of Baton Rouge, Inc.

Event ID: MF6U11

Medicaid ID: N/A

State ID: BO0004642

Dear Ms. Cochran:

On 02/03/2011, a health survey was conducted at the above referenced facility. At that time it was determined that the facility was out of compliance with the federal and/or state rules for Abortion Clinics. Specifically, the facility had deficient practices in the following areas:

St - S - 4405 - - Governing Body

St - S - 4415 - - Patient Records And Reports

This office has determined that your facility's failure to comply with these rules constitutes separate Class "C" violations pursuant to a final rule published by this Department in July of 2000, in that the above referenced facility's actions or inactions created a potential for harm by directly threatening the health, safety, rights or welfare of a patient(s). As a result of these infractions, we are assessing this facility a Civil Fine of \$1,000.00 for the violations under Tag S-4405 and a Civil Fine of \$1,000.00 for the violations under Tag S-4415, as referenced in this letter.

Therefore, the total amount of the Civil Fines assessed against this facility for these seperate Class "C" violations, as referenced in this letter, is \$2,000.00.

Further details of these violations are included in the 02/03/2011 survey statement of deficiencies, Form CMS-2567 (previously received by this facility) which are incorporated by reference herein.

You may request an Informal Reconsideration of this decision to impose a civil fine. The request for Informal Reconsideration must be in writing and must be forwarded to the following address:

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IDR Program Manager BHSF, Health Standards Section P. O. Box 3767 Baton Rouge, LA 70821-3767

Your request for Informal Reconsideration must be received by this office within ten (10) days from receipt of this notice letter and must include any documentation that you think demonstrates this determination was made in error. If a timely request for the Informal Reconsideration is received by this office, an Informal Reconsideration will be scheduled and you will be notified of the time and place. The reconsideration decision shall be based upon all documentation and oral testimony furnished by the provider to the department at the time of the Informal Reconsideration.

You also have the right to an **Administrative Appeal** regarding this decision. If you desire to appeal the proposed civil fine, you must file a written request within thirty (30) days after receipt of this notice letter. Your request for an Administrative Appeal must be forwarded to the following:

Division of Administrative Law HH Section Post Office Box 4189 Baton Rouge, LA 70821-4189

You may choose to waive or forego the right to an Administrative Reconsideration and proceed directly to an Administrative Appeal. If you choose this option, you must file a written request for an Administrative Appeal within thirty (30) days after receipt of this notice letter. Your request for an Administrative Appeal must be forwarded to the Division of Administrative Law, at the address cited in the paragraph above.

The Division of Administrative Law will require a party requesting an appeal to (1) post an appeal bond with the HH Section as provided in La. R.S. 40:2199(D), or (2) file a devolutive appeal wherein the facility pays the civil fine pending the outcome of the appeal.

Please note that the request for an Informal Reconsideration does not constitute a request for an Administrative Appeal, nor does it extend the time limit for requesting an Administrative Appeal.

Also, please note that if you do not request an Administrative Reconsideration or an Administrative Appeal, this letter constitutes notice of this Department's <u>final</u> decision to impose a sanction. Once the delays for filing for an Administrative Reconsideration and/or Administrative Appeal have run, the decision to impose this Civil Fine becomes final and you must remit your payment within ten (10) days to:

La. Department of Health and Hospitals ATTN: James Taylor, Sanction Desk Post Office Box 3767 Baton Rouge, LA 70821-3767

Upon remittance, clearly indicate that the check is for payment of a civil monetary penalty.

If you have any questions regarding this letter, please contact James H. Taylor, III at (225) 342-5457.

Sincerely,

BHSF, Health Standards Section

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Section Chief

ERNHT

cc. File Copy

Abortion Clinic Program Desk

Mike Chapman, Financial Management