NEW MEXICO DEPARTMENT OF HEALTH

OPERATOR'S LICENSE

1T 3522
License Number

5/5/2015
Issue Date

Total Capacity

9/2/2015
Expiration Date

Capacity Breakdown:

Ownership Name: THE BOOYAH GROUP, LLC

is hereby licensed to maintain and operate a/an: LIMITED DIAGNOSTIC AND TREATMENT CENTER

under the name and in the location of:

Whole Woman's Health Of New Mexico, Llc

3900 E LOHMAN AVE STE B

LAS CRUCES NM 88011

NON-TRANSFERRABLE
The authority to operate a health facility granted hereunder shall not be transferred to any other person or location.

ANDREA FERRIGNO
Administrator/Director/Operator

Retta Ward
DOH Secretary

DIVISION OF HEALTH IMPROVEMENT
HEALTH FACILITY LICENSING AND CERTIFICATION BUREAU

NEW MEXICO DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH
Retta Ward, Secretary
DIVISION OF HEALTH IMPROVEMENT
Jack Evans, Division Director
HEALTH FACILITY LICENSING AND CERTIFICATION BUREAU
Amber Espinosa-Trujillo, Bureau Chief

MEDICAL LICENSURE APPLICATION

Section I (Please Print or Type) Information *provided in this section will appear on license*

Name of Facility: Whole Woman's Health of New Mexico, LLC	☒ **Profit** ☐ **Non Profit**
Physical Address of Facility: 3900 E. Lohman Ave. Ste. B	
City, State and Zip Code: Las Cruces, NM 88011	
Mailing Address: *(if different than physical address)* Same as above	
Telephone: (512) 835 6858	**Fax:** (512) 832 6568
On-site Administrator/CEO/Director: *(Application **must** contain notarized signature of onsite Administrator on Reverse)* Andrea Ferrigno, Administrator	**E-mail address:** andrea@wholewomanshealth.com
Facility License Number: *(if currently licensed)* 3522	**Medicare Provider Number:** / **Medicaid Provider Number:**

Section II (Please Check all that apply)

TYPE OF APPLICATION:	**Date of Change**
☒ Initial	
☐ Renewal - Current Capacity _____	
☐ Change of Ownership	
Amended License:	
☐ Change of Name	
☐ Change of Capacity: ☐ Increase ☐ Decrease Change from _____ to _____	
☐ Change of Physical Address	
☐ Change of Administrator/CEO	

APPLICATION FOR: ☐ Certification ☒ Licensed Only

- ☐ Ambulatory Surgical Center
- ☐ Community Mental Health Center ☐ Parent ☐ Branch
- ☐ Diagnostic and Treatment Center
- ☒ Limited Diagnostic and Treatment Center (Certified OPT)
- ☐ Hospice ***Please specify:*** ☐ Parent ☐ Alternative Site
- ☐ Inpatient Hospice _____# of Beds ☐ Licensed Only
- ☐ Infirmary _____# of Beds
- ☐ Rural Health Clinic
- ☐ ESRD # of Stations _____
- ☐ Home Health Agency

Please Specify: ☐ Parent ☐ Branch
(Please check below, services offered)

- ☐ Home Health Aide
- ☐ Respiratory Therapy
- ☐ Infusion Therapy
- ☐ Skilled Nursing
- ☐ Occupational Therapy
- ☐ Social Services
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Waivers (Indicate Type)
  - ☐ DD
  - ☐ D & E
  - ☐ Medically Fragile Children
  - ☐ HIV/AIDS
- ☐ Other (Specify) _____

FOR BUREAU USE ONLY

Date Received: RECEIVED SEP 12 2014 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Fee Amount: 2343-20 PAID $4300 CK# 2040 Ref# 142306 Cash 5-14-2015

All applications must be accompanied by the required fee (see attached fee schedule) in the form of a check or money order payable to the **"STATE OF NEW MEXICO."**

FEES ARE NON-REFUNDABLE

SEE REVERSE SIDE

Section III OWNERSHIP (*All Persons owning 5% or Greater*) **(Use additional sheets, if necessary)**

NAME	ADDRESS	TELEPHONE NO.
The Booyah Group, LLC	8401 N IH 35, Suite 1A. Austin, TX 78753	(512) 835 6858

TYPE OF OWNERSHIP: ☐ Individual ☒ Corporation ☐ Partnership ☐ Non-profit Organization ☐ Church ☐ School ☐ Government or Association ☐ Tribal

Ownership Name: The Booyah Group, LLC

Section IV

Have you or any of the individuals or entities listed in Section III ever owned, operated, or otherwise administered all or part of a health facility in any jurisdiction whose facility license has been revoked or denied? ☐ Yes ☒ No If yes, please indicate what facility, date and why the action(s) was taken: (Use additional sheets, if necessary)

Are you now in the process of being, or have you ever been, sanctioned by DHI for failure to comply with any of its regulations? ☐ Yes ☒ No If yes, please explain and describe the status of those sanctions in detail. (Use additional sheets, if necessary)

Have you or any of the individuals listed in Section III ever been convicted of a felony? [redacted]

If yes, state the type of conviction(s), date, Judge, Court of Jurisdiction and address. (Use additional sheets, if necessary)

Section V AFFIDAVIT

I hereby certify that I have read and understand the laws and regulations applicable to this facility and I assume responsibility for the conduct of affairs for the facility. I declare under penalty of perjury, under the laws of the State of New Mexico, that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer(s) to any question(s) may lead to prosecution under the laws of the State of New Mexico, and may be grounds for denial or subsequent revocation of the license.

On-site Administrator or Director (Signature) — Date Signed: 08/13/14

FOR NOTARY USE ONLY

I, Debbie May
(Please Print Notary Name)

State of Texas
(Indicate State)

County of Travis
(Indicate County)

DEBBIE MAY NOTARY PUBLIC STATE OF TEXAS EXPIRES 01-10-2015

Sworn to and Subscribed Before me:

This 13th day of August 2014

Notary Public

My Commission Expires: 1-10-2015

ALL APPLICATIONS MUST BE NOTARIZED

INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT THE APPROPRIATE FEES WILL NOT BE PROCESSED. Please return this application to: Department of Health, Division of Health Improvement- Health Facility Licensing & Certification Bureau – PO Box 25886, Albuquerque, NM 87125