

OPERATOR'S LICENSE

1 T 3522

5/5/2015

Capacity Breakdown:

License Number

Issue Date

Total Capacity

9/2/2015

Expiration Date

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

NON-TRANSFERRABLE

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

3900 E LOHMAN AVE STE B

LAS CRUCES

NM 88011

ANDREA FERRIGNO
Administrator/Director/Operator

DOH Secretary

DIVISION OF HEALTH IMPROVEMENT
HEALTH FACILITY LICENSING AND CERTIFICATION BUREAU



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		<input checked="" type="checkbox"/> Profit	<input type="checkbox"/> 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 <u>must</u> 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	APPLICATION FOR: <input type="checkbox"/> Certification <input checked="" type="checkbox"/> Licensed Only
<input checked="" type="checkbox"/> Initial		<input type="checkbox"/> Ambulatory Surgical Center
<input type="checkbox"/> Renewal - Current Capacity _____		<input type="checkbox"/> Community Mental Health Center <input type="checkbox"/> Parent <input type="checkbox"/> Branch
<input type="checkbox"/> Change of Ownership		<input type="checkbox"/> Diagnostic and Treatment Center
Amended License:		<input checked="" type="checkbox"/> Limited Diagnostic and Treatment Center (Certified OPT)
<input type="checkbox"/> Change of Name		<input type="checkbox"/> Hospice Please specify: <input type="checkbox"/> Parent <input type="checkbox"/> Alternative Site
<input type="checkbox"/> Change of Capacity: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease Change from _____ to _____		<input type="checkbox"/> Inpatient Hospice _____ # of Beds <input type="checkbox"/> Licensed Only
<input type="checkbox"/> Change of Physical Address		<input type="checkbox"/> Infirmary _____ # of Beds
<input type="checkbox"/> Change of Administrator/CEO		<input type="checkbox"/> Rural Health Clinic
FOR BUREAU USE ONLY Date Received _____ Fee Amount _____ 2343-20 5-14-2015 PAID \$4300.00 Ch# 2040 Ref# 142367 RECEIVED SEP 12 2014 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU 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		<input type="checkbox"/> ESRD # of Stations _____
		<input type="checkbox"/> Home Health Agency
		Please Specify: <input type="checkbox"/> Parent <input type="checkbox"/> Branch (Please check below, services offered)
		<input type="checkbox"/> Home Health Aide <input type="checkbox"/> Respiratory Therapy
		<input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Skilled Nursing
		<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Social Services
		<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy
		<input type="checkbox"/> Waivers (Indicate Type) <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> DD <input type="checkbox"/> D & E
		<input type="checkbox"/> Medically Fragile Children
		<input type="checkbox"/> HIV/AIDS

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
Organization

☒ Corporation☐ Partnership☐ Non-profit☐ 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?

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.

[Signature]
On-site Administrator or Director (Signature)

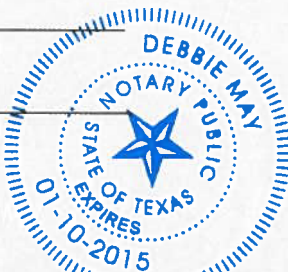
08/13/14
Date Signed

FOR NOTARY USE ONLY

I, Debbie May
(Please Print Notary Name)

State of TEXAS
(Indicate State)

County of TRAVIS
(Indicate County)



Sworn to and Subscribed Before me:

This 13th day of August 2014

Notary Public [Signature]

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