TEXAS DEPARTMENT OF STATE HEALTH SERVICES
REGULATORY LICENSING UNIT

Ambulatory Surgical Center License

This is to certify that

PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER
2140 BABCOCK ROAD
SAN ANTONIO, TX 78229

is licensed as an Ambulatory Surgical Center under the provision of the Health and Safety Code, Chapter 243, and the Ambulatory Surgical Center Licensing Rules.

License Number: 130241

Expiration Date: 06/30/2017

Non-Transferable

121653

DEPT. ID ZZ101/FUND 168

Application for a License to Operate an Ambulatory Surgical Center

10-15-14
M 001601
$5200 xx

☒ Initial
Projected Date Center Will Open: 1-10-2015 Architectural Project or Application #: 13199

☐ Change of Ownership
Effective Date: _____ Current License #: _____

☐ Relocation
Projected Date Center Will Open: _____ Current License #: _____
Architectural Project or Application #: _____

1. Center Information:

FILE # 910 ENTITY # 1640259

a. Name the center will be doing business as (d/b/a):

Planned Parenthood South Texas Surgical Center

b. Street Address: 2140 Babcock Road
Street Number

San Antonio, Texas 78229 Bexar
City/State/Zip County

Received
OCT 16 2014
DSHS/RLU/FLG

c. Mailing Address: _____
(If different) Street or P.O. Box Number

_____
City/State/Zip

d. Telephone Number (include area code) Fax Number (include area code)

(210) 736-2244 (210) 736-0011
Leave blank if number is unknown at this time. *Leave blank if number is unknown at this time.*

2. Ownership Information:

FILE # 1627 ENTITY # 916556

Planned Parenthood South Texas Surgical Center
Name of Owner *(entity legally responsible for the operation of the center, whether by lease or ownership)*

104 Babcock Road San Antonio, Texas 78201
Mailing Address City/State/Zip

20-2851697 (210)736-2244 polin.barraza@ppsouthtexas.org
Tax ID Number or SS# Telephone Number E-Mail Address

Status: ☐ Profit ☒ Non-Profit

Type of Ownership:
☐ Sole Proprietor ☐ County ☐ Limited Liability Company ☐ LTD
☒ Corporation ☐ City ☐ Limited Liability Partnership ☐ LP
☐ Partnership ☐ City-County ☐ Hospital District/Authority ☐ Other: _____

3. Ownership and Control Interest Disclosure:

a. The owner must disclose the following data for the two-year period preceding the application date. Check yes or no to the following questions. If yes is checked, you must provide details, including ownership and facility information, circumstances, dates and final action, on a separate sheet with this application.

1. Eviction involving any property used as a health care facility in any state?	Yes ____	No X
2. Federal or state (any state) tax liens?	Yes ____	No X
3. Unsatisfied final judgments?	Yes ____	No X
4. Federal or state (any state) criminal misdemeanor arrests or convictions?	Yes ____	No X
5. Injunctive orders from any court?	Yes ____	No X
6. Unresolved final state or federal Medicare or Medicaid audit exceptions?	Yes ____	No X

b. The owner must disclose the following data. Check yes or no to each question. If yes is checked, provide details on a separate sheet, including all ownership and facility information, circumstances, dates and final action.

1. Denial, suspension, or revocation of ambulatory surgical center license or any health agency in any state or any other enforcement action?	Yes ____	No X
2. Denial, suspension or revocation or other enforcement action against a health care facility license in any state, which is or was proposed by the licensing agency and the status of the proposal?	Yes ____	No X
3. Surrendered a license before expiration of the license or allowing a license to expire in lieu of the department proceeding with enforcement action?	Yes ____	No X
4. Federal or state (any state) criminal felony arrests or convictions?	Yes ____	No X
5. Federal or state Medicaid or Medicare sanctions or penalties relating to the operation of a health care facility?	Yes ____	No X
6. Operating a health care facility that has been decertified with Medicare or Medicaid?	Yes ____	No X
7. Debarment, exclusion, or contract cancellation from Medicare or Medicaid in any state?	Yes ____	No X

4. Licensing Fee:

☒ Initial	$5,200.00	
☐ Change of Ownership	$5,200.00	*(A Bill of Sale is required for change of ownership applications. It can be submitted separately from the license application.)*
☐ Relocation	$5,200.00	

Fees paid to the Department are not refundable. Application will not be processed without the appropriate fee.

5. Services:

Mark all surgical specialties that are offered at this center:

☐ Cardiovascular	☐ Foot	☐ General	☐ Gastroenterology
☐ Neurological	☒ OB/GYN	☐ Ophthalmology	☐ Pain Management
☐ Oral	☐ Orthopedic	☐ Otolaryngology	☐ Chiropractic
☐ Plastic	☐ Thoracic	☒ Urology	☐ Endoscopy
☒ Abortion	☐ Other (Specify) _____		

6. Accreditation (CHOWS and RELOCATIONS ONLY):

☐ JCAHO ☐ AAAHC ☐ AAAASF ☐ AOA ☒ Other ☐ None ☐ Pending

If applicable, attach a copy of the accreditation letter or certificate from the accrediting agency.

Name of Center: Planned Parenthood South Texas Surgical Center **DEPT. ID ZZ101/FUND 168**

7. Total # of Operating Rooms: 2 **Total # of Treatment/Procedure Rooms:** 0

8. Medical Staff:

a. Provide the total number of physicians, dentists, podiatrists, and/or advanced practice registered nurses on staff at the center.

Physicians 3 Dentists _____ Podiatrists _____ APRNs 6

b. Medical Chief of Staff:

Dallas Johnson, M.D.	H4441	05/31/2015
Name	License #	Expiration Date *(mm/dd/yyyy)*

c. Director of Nurses:

Clora Nichole Johnson	714544	08/31/2016
Name	License #	Expiration Date *(mm/dd/yyyy)*

9. Administrator's Signature:

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 135, Ambulatory Surgical Centers. The administrator attests that all information contained in this application is true and correct. The administrator attests that all copies submitted with the application are original copies or copies of the original documents.

Polin C. Barraza, RN
Administrator's Name **(Please Print)**
Person responsible for day-to-day operations at the center

Vice Chair & Secretary
Title

Polin C. Barraza, RN
Administrator's Signature

10-7-2014
Date Signed

polin.barraza@ppsouthtexas.org
Administrator's Email Address

(210) 736-2244, ext. 334
Administrator's Telephone Number

10. Contact Person:

Polin C. Barraza, RN
Name of the person completing this application

Vice Chair & Secretary
Title

(210) 736-2244, ext. 334
Telephone Number

polin.barraza@ppsouthtexas.org
Email Address

Mailing address for applications with fees: Department of State Health Services, Facility Licensing Group, Mail Code 2003, PO Box 149347, Austin, TX 78714-9347

Overnight mailing address for applications with fees: Department of State Health Services, Facility Licensing Group, Mail Code 2003, 1100 West 49th Street, Austin, TX 78756