

STATE OF CONNECTICUT
Department of Public Health
LICENSE

License No. 0009

Outpatient Clinic

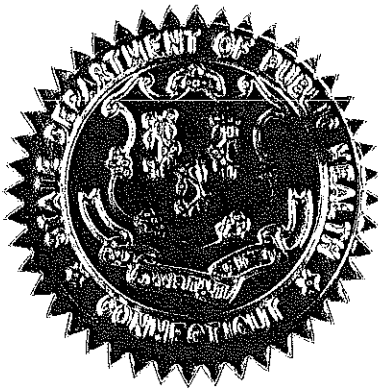
In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
Connecticut Public Health Code, Section 19-13-D54 and Section 19a-116-1:

Hartford Physician'S Management Corp of Hartford, CT, d/b/a Hartford Gyn Center is hereby licensed
to maintain and operate a Family Planning Clinic.

Hartford Gyn Center is located at 1 Main Street, Hartford, CT 06106.

This license expires **June 30, 2013** and may be revoked for cause at any time.

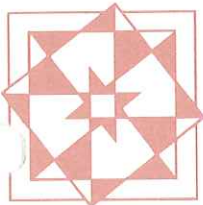
Dated at Hartford, Connecticut, July 1, 2009. RENEWAL.



J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA, Commissioner

CHANGE IN KEY PERSONNEL



HARTFORD
GYN
CENTER

Rose McClellan
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

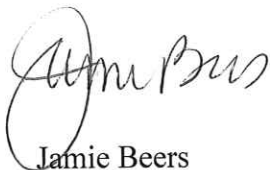
March 1, 2012

Dear Ms. McClellan,

The purpose of this letter is to notify the Department of Public Health ("Department") that Hartford GYN Center, an outpatient clinic licensed to operate a family planning clinic, license number 0009 ("Center"), has appointed a new medical director. Carol Watson, M.D., a physician licensed in the State of Connecticut who specializes in obstetrics and gynecology, will be assuming the position of Medical Director at the Center effective March 1, 2012. The Center's prior medical director, Dr. Janice Lee, resigned her position to pursue other opportunities after serving as the medical director for 13 years. If you would like additional information regarding Dr. Watson, please feel free to contact Jamie Beers, Administrator at 860-525-1900."

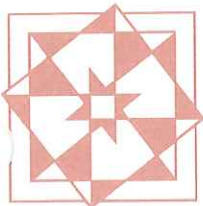
If you have any questions regarding the forgoing, feel free to contact us.

Regards,



Jamie Beers
Administrator





HARTFORD
GYN
CENTER

Wendy Furniss
Healthcare Systems
Branch-Bureau Chief
410 Capitol Avenue
Hartford, CT 06134

March 1, 2012

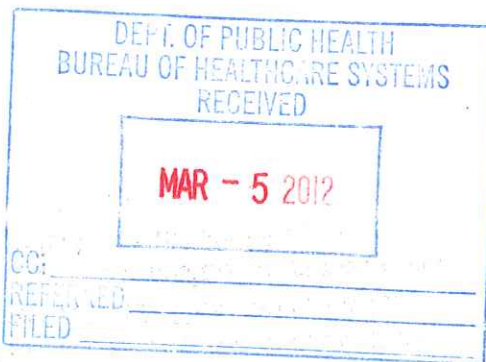
Dear Ms. Furniss,

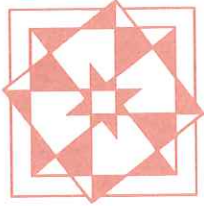
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Regards,

Jamie Beers
Administrator





HARTFORD
GYN
CENTER

November 30, 2010

Director
Department of Public Health, State of CT
410 Capitol Ave.
MS-12HSR
PO Box 340308
Hartford, CT. 06134

Dear Director,

This is to notify you that there has been a change in the Administrator position at Hartford Gyn Center, located at One Main Street, Hartford, CT.

I, Jamie Beers, have been appointed to the position of Administrator of the Center following the departure of Ms. Jessica Wilson.

I will extend my full cooperation to the Department of Public Health and will be available to the Department when needed. I look forward to working with the Department of Public Health to provide the best possible care at Hartford Gyn Center.

Sincerely,

Jamie L. Beers
Administrator

RECEIVED
2010 DEC -5 P 4: 16
DEPT. OF PUBLIC HEALTH
STATE OF CONNECTICUT

cc:

Elizabeth Barnes
Carrie Bruist
Valerie Baker



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSE & INVESTIGATIONS SECTION

Page 1 of

LICENSURE APPLICATION

[] INITIAL [X] RENEWAL

NOTE: A separate application must be completed for each licensed level of care which is located at a different address. One (1) application may be submitted for multiple levels of care provided each level of care has the same name and the same licensee and is located at the same address.

In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application is hereby made for a license to operate the following (please check the appropriate box/boxes that apply):

- | | |
|--|---|
| <input type="checkbox"/> Assisted Living Services Agency | <input type="checkbox"/> Infirmary Operated by an Educational Institution |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Maternity Home |
| <input type="checkbox"/> Chronic and Convalescent Nursing Home | <input type="checkbox"/> Maternity Hospital |
| <input type="checkbox"/> Chronic Disease Hospital | <input checked="" type="checkbox"/> Outpatient Clinic |
| <input checked="" type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Outpatient Dialysis Unit |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Outpatient Surgical Facility |
| <input type="checkbox"/> Home Health Care Agency | <input type="checkbox"/> Residential Care Home |
| <input type="checkbox"/> Homemaker-Home Health Aide Agency | <input type="checkbox"/> Rest Home with Nursing Supervision |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Well Child Clinic |
| <input type="checkbox"/> Hospital for Mentally Ill Persons | <input type="checkbox"/> Mental Health Day Treatment |
| <input type="checkbox"/> Mental Health Psychiatric OutPat. | <input type="checkbox"/> Mental Health Community Residence |
| <input type="checkbox"/> Mental Health Intermediate Tmt. | <input type="checkbox"/> Mental Health Residential Living |
| <input type="checkbox"/> Substance Abuse & Dependence | |

Please respond to all of the following questions:

- ✓ 1. Hartford Gyn Center
Facility "d/b/a" (doing business as) Name
- One Main Street Suite N1 Hartford, CT 06106 525-1900
Business Address City State Zip Code Telephone (860)
- Same as above
Mailing Address (if applicable) City State Zip Code



Phone: (860) 509-7444
Telephone Device for the Deaf (860) 509-719
410 Capitol Avenue - MS # 12HFL
P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

2. Bed Capacity Requested (if applicable). If submitting this application for multiple levels of care, please list the bed capacity for each level of care being requested.

<u>Level of Care</u>	<u>Beds/ Hemodialysis Stations</u>	<u>Bassinets (if applicable)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. 23-214 9551
Federal Employer Identification Number

4. Disclose the legal entity which owns/operates the facility. (Note: The license will be issued to this entity.)

Hartford Physicians Management Corp (d/b/a Hartford Gyn Center)
Licensee

One Main Street Suite N1 Hartford, CT 06106 860-525-1900
Business Address City State Zip Code Telephone

Same as above
Mailing Address (if applicable)

5. Is the above named legal entity a (please check the box which applies):

<input type="checkbox"/> Individual/Sole proprietor	<input type="checkbox"/> Municipality
<input type="checkbox"/> General Partnership	<input type="checkbox"/> Trust
<input type="checkbox"/> Limited Partnership	<input checked="" type="checkbox"/> Profit Corporation
<input type="checkbox"/> Limited Liability Company	
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Non-profit Corporation	

6. Is the above named entity authorized by the Office of the Secretary of State to transact business in the State of Connecticut and considered in Good Standing? ☒ YES ☐ NO

7. Please disclose the name, business address and telephone number of the Agent for Service for the Licensee.

Jessica L. Wilson (Administrator) One Main St Suite N1 Hfd, CT (860) 525-1900
Name Address City State Zip Code Telephone

8. Attach an organizational chart which reflects the current ownership structure of the licensee and the licensee's relationship with the facility/agency.

FACILITY FAX # (860) 522-9913



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

Attachment 3

FORM 3

FACILITY/AGENCY NAME: Hartford Gyn Center

Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. Please complete a separate form for each legal entity listed below that is not an individual.

This information is for:

☒ Licensee Hartford Physician's Management Corp d/b/a
☐ Real Property Owner Hartford Gyn Center

1. Name: Humedco Corp.
Address: 500 Kings' Highway North - Suite 300 - Cherry Hill, N.J.
Telephone: (856) 414-1120
Stockholder's percentage of ownership: 100%
Stockholder's occupation with the owner: Management company
2. Name: _____
Address: _____
Telephone: _____
Stockholder's percentage of ownership: _____
Stockholder's occupation with the owner: _____
3. Name: _____
Address: _____
Telephone: _____
Stockholder's percentage of ownership: _____
Stockholder's occupation with the owner: _____
4. Name: _____
Address: _____
Telephone: _____
Stockholder's percentage of ownership: _____
Stockholder's occupation with the owner: _____

RECEIVED
2009 MAY 21 P 4:55
DEPT. OF PUBLIC HEALTH
DIVISION OF FACILITY
LICENSING & REGULATION

Client#: 153205

HUMEDCOR

ACORD™ CERTIFICATE OF LIABILITY INSURANCEDATE (MM/DD/YYYY)
06/05/2009

PRODUCER

The NIA Group, LLC
One Executive Drive
P.O. Box 6728
Somerset, NJ 08875-6728

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

Hartford GYN Center
One Main Street, Unit N-1
Hartford, CT 06106

INSURERS AFFORDING COVERAGE

NAIC

INSURER A: Landmark American Insurance Com

33138

INSURER B:

INSURER C:

INSURER D:

INSURER E:

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L LTR	INSR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
		GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO. JECT <input type="checkbox"/> LOC				EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$
		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN EA ACC \$ AUTO ONLY: AGG \$
		EXCESS / UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE \$ RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under SPECIAL PROVISIONS below				WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A		OTHER Professional Liability	LHM811197 \$50,000 deduct	02/28/2009	02/28/2010	\$1,000,000 per claim \$3,000,000 per loc agg \$5,000,000 policy agg

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Evidence of insurance

CERTIFICATE HOLDER

EVIDENCE OF INSURANCE

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE



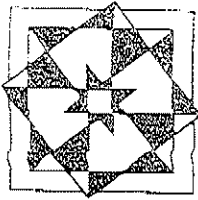
IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.



HARTFORD
GYN
CENTER

May 21, 2009

Ms. Rose McLellan
Licensing Examination Assistant
State of Connecticut
Department of Public Health
410 Capitol Avenue MS #12HFL
P.O. Box 340308
Hartford, CT 06134

Dear Ms. McLellan:

I am faxing the Fire Marshall's Inspection certificate, which should complete the paperwork for our State License Renewal. The rest of the packet was sent from our New Jersey office and it should have been received in your office today.

Please let me know if you have any questions or need any further information regarding the renewal process.

Sincerely,

Jessica L. Wilson
Clinic Administrator

JLW/mmd

Department of Public Safety
Division of Fire, Emergency & Building Services
Office Of State Fire Marshal



STATE OF CONNECTICUT

On (date) 5-21-09, the City/Town Hartford Office of the Fire Marshal
conducted an inspection of (name of facility) HARTFORD GYN
located at (address) 1 MAIN ST in the
City/Town of Hartford to determine the degree of compliance with the
fire safety requirements of Connecticut General Statutes Chapter 541 as authorized by
Section 29-305 of the statutes. This facility was evaluated as a (new/existing) EXISTING
(occupancy classification) HEALTH CARE FACILITY as classified
by the CONNECTICUT FIRE SAFETY CODE. As a result of this inspection, the following
conditions were found:

- ☒ I. At the time of inspection, no code violations were identified.
Certificate of approval recommended.
- ☐ II. At the time of inspection, conditions were discovered to be contrary to the minimum
requirements of these codes. An acceptable plan of correction was submitted. (See
attached information) Certificate of approval recommended.
- ☐ III. At the time of inspection, conditions were discovered to be contrary to the minimum
requirements of these codes. No approved plan of correction was submitted. (See
attached information) Certificate of approval NOT recommended.
- ☐ IV. Based on the extreme hazard to public safety discovered at the time of this inspection,
this office is currently seeking an injunction from the court through our Town/City
Attorney for the purpose of closing or restricting usage of this facility by the public.
(See attached information) Certificate of approval NOT recommended.

Edward Casares Jr

Fire Marshal

Insp Martin Agones

5-21-09

Date

City Town: Hartford

Client#: 153205

HUMEDCOR

ACORD™ CERTIFICATE OF LIABILITY INSURANCEDATE (MM/DD/YYYY)
06/10/2009

PRODUCER

The NIA Group, LLC
One Executive Drive
P.O. Box 6728
Somerset, NJ 08875-6728

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INSURERS AFFORDING COVERAGE

NAIC #

INSURED

Hartford Physicians' Management Corp dba
Hartford GYN Center
500 Kings Highway N #30
Cherry Hill, NJ 08034-2581

INSURER A: Scottsdale Insurance Company

41297

INSURER B: Granite State Insurance Company

23809

INSURER C:

INSURER D:

INSURER E:

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

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		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	\$ \$ \$ \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	\$ \$ \$
		EXCESS / UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$				EACH OCCURRENCE AGGREGATE	\$ \$ \$ \$
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under SPECIAL PROVISIONS below <input type="checkbox"/> Y/N OTHER	WC2931283	07/01/2008	07/01/2009	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	\$1,000,000 \$1,000,000 \$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Evidence of Insurance

CERTIFICATE HOLDER

CANCELLATION

EVIDENCE OF INSURANCE

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AUTHORIZED REPRESENTATIVE



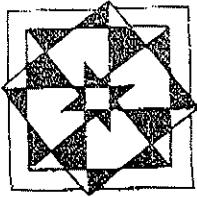
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HARTFORD
GYN
CENTER

May 21, 2009

Ms. Rose McLellan
Licensing Examination Assistant
State of Connecticut
Department of Public Health
410 Capitol Avenue MS #12HFL
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Sincerely,

Jessica L. Wilson
Clinic Administrator

JLW/mmd

Department of Public Safety
Division of Fire, Emergency & Building Services
Office Of State Fire Marshal



STATE OF CONNECTICUT

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City/Town of Hartford to determine the degree of compliance with the
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Attorney for the purpose of closing or restricting usage of this facility by the public.
(See attached information) Certificate of approval NOT recommended.

Edward Casares Jr

Fire Marshal

Insp Martin A Jones

5-21-09

Date

City Town: Hartford

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA. 13072

26814-0000

WC 293-12-83

013-82-0708-00

INCORPORATED UNDER THE LAWS OF

PENNSYLVANIA

ITEM 1. NAMED INSURED: MAILING ADDRESS IDENTIFICATION NO.

HUMEDCO CORP. PHILADELPHIA WOMEN'S CENTER, INC.;
 (SEE WC990013 FOR COMPLETE NAME)
 500 KINGS HIGHWAY NORTH, STE 300
 CHERRY HILL, NJ 08034-0000



Member Companies of
 American International Group

EXECUTIVE OFFICES:

70 PINE STREET, NEW YORK, N.Y. 10270

SEE EXTENSION OF ITEM 1. OF THE INFORMATION PAGE - WC990610

I.D.#

PRODUCERS NAME AND ADDRESS

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY INFORMATION PAGE

SMITH BELL & THOMPSON INC.
 PO BOX 730
 BURLINGTON, VT 05402-5117

INSURED IS
CORPORATION

PREVIOUS POLICY NUMBER

RENEWAL 006847111

OTHER WORKPLACES NOT SHOWN ABOVE: SEE EXTENSION OF ITEM 1. OF THE INFORMATION PAGE - WC990610

ITEM 2 POLICY PERIOD 12:01 A.M. standard time at the insured's
 mailing address FROM 07/01/08 TO 07/01/09

ITEM 3 A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed
 here:
 CT GA NJ PA

B. Employers Liability Insurance: Part Two of the policy applies to the work in each state listed in item 3.A.
 The limits of our liability under Part Two are:

Bodily Injury by Accident \$ 1,000,000 each accident
 Bodily Injury by Disease \$ 1,000,000 policy limit
 Bodily Injury by Disease \$ 1,000,000 each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

AK AL AR AZ CO DC DE FL HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS MT NC NE NH NM NV
 NY OK OR RI SC SD TN TX UT VA VT WI

D. This policy includes these

SEE EXTENSION OF ITEM 3.D. OF THE INFORMATION PAGE - WC990612

ITEM 4 The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans.
 All information required below is subject to verification and change by audit.

Classifications

Code Number

Estimated Total
Remuneration
☒ Annual ☐ 3 Year
Rate Per
\$100 OF Re-
munerationEstimated
Premium
☒ Annual ☐ 3 Year

SEE EXTENSION OF ITEM 4. OF THE INFORMATION PAGE - WC7754
 TAXES/ASSESSMENTS/SURCHARGES

\$931

EXPENSE CONSTANT (EXCEPT WHERE APPLICABLE BY STATE)

\$220 NJ

MINIMUM PREMIUM

\$850 CT

TOTAL ESTIMATED PREMIUM

\$22,466

If indicated below, Interim adjustments of premium shall be made:

☐

Semi-Annually

☐

Quarterly

☐

Monthly

DEPOSIT PREMIUM

06/18/08 PARSIPPANY

82

Issue Date

Issuing Office

Authorized Representative

WC 00 00 01

39967 (Rev'd 04/08)

9.

Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**

A. If the Licensee is a **general partnership, limited partnership or limited liability company**, complete Form 1 (attached).

B. If the Licensee is a **trust**, complete Form 2 (attached) for the Licensee.

i. Attach a list including the name, address and telephone number of all trustees.

C. If the Licensee is a **corporation (profit or non-profit)**, complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.

i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.

ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.

✓ 10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.

✓ 11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:

- A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
- B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
- C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)

✓ 12. Ownership of Real Property

Polis and Sanders (CT), L.L.C.
 Name
500 Kings Highway North Suite 300 Cherry Hill, NJ 08034
 Business Address City State Zip Code Telephone (856) 414-1120

✓ 13. Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. **NOTE: Hospitals must have a separate Fire Marshal's Certificate of Inspection completed for each building on the hospital's campus and each satellite listed on the hospital's license. Additional forms may be copied if necessary. Each completed Fire Marshal's Certificate of Inspection that is submitted must have an original signature. (Not applicable for ALSA's, Homemaker Home Health and Home Health Agencies).**

Officers for Hartford Gyn Center, Inc.
5/20/2009

President	Randy Lazarus
Vice President	Elizabeth Barnes
Treasurer	Susan Cohen
Secretary	Susan Cohen
Assistant Secretary	Kimberly Pisani

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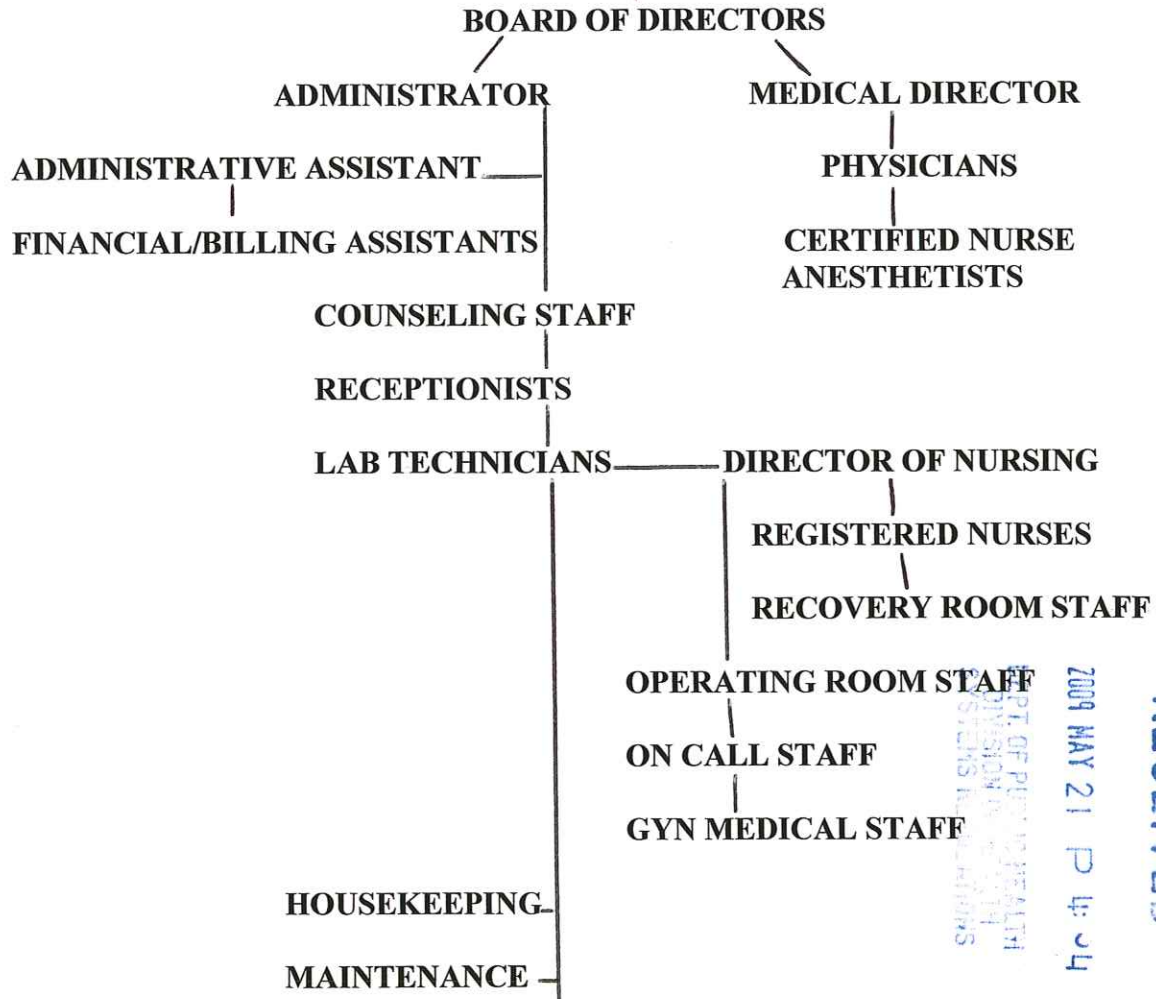
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DEPT. OF PUBLIC HEALTH
DIVISION OF HEALTH
SYSTEMS REGULATIONS

**HARTFORD GYN CENTER
ORGANIZATIONAL CHART**

**HUMEDCO CORP
(100% Shareholder)**

**HARTFORD PHYSICIAN'S MANAGEMENT CORP
D/B/A HARTFORD GYN CENTER
(Licensee)**



FOR OFFICE USE ONLY

CHECK # 10492

AMOUNT \$ 1,000.00

DATE RECEIVED 5/21/09

INITIALS CR

14. Affidavit of Owner:

I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

Susan Cohen
Signature

5/20/09
Date Signed

Check one as applicable:

- ☐ Individual/Sole Proprietor
- ☐ General/Managing Partner
- ☐ President of Corporation
- ☒ Secretary of Corporation
- ☐ Municipal Officer
- ☐ Trustee

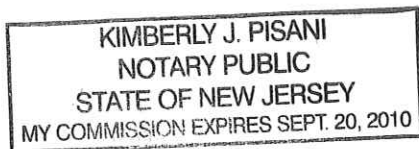
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 DIVISION OF REGULATIONS

State of Connecticut)

County of Camden)

ss 5-20 20 09

Personally appeared before me the above named Susan Cohen and made oath to the truth of the statements contained in his/her answers to the foregoing questions.



Kim A. Pisani
 Notary Public ☒
 Justice of the Peace ☐
 Town Clerk ☐
 Commissioner of the Superior Court ☐

My Commission Expires: 9-20-2010
 (If Notary Public)



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

**OUTPATIENT CLINICS, WELL CHILD CLINICS AND
 FAMILY PLANNING CLINICS**

Please respond to all of the following questions:

1. Hartford Gyn Center
 Facility "d/b/a" (doing business as) Name
One Main Street Suite N1 Hartford, CT 06106 (800) 525-1900
 Business Address City State Zip Code Telephone
2. Check the appropriate box/boxes describing the services to be provided by the clinic:

<input type="checkbox"/> Primary Care	<input checked="" type="checkbox"/> Family Planning
<input type="checkbox"/> Well Child Clinic	<input checked="" type="checkbox"/> Abortion Procedures
<input type="checkbox"/> Dental	
3. Jessica L. Wilson
 Administrator (Your name needs to appear as it is shown on your Professional License).
4. Janice L. Lee, M.D. NA
 Medical Director Dental Director (if applicable)
 (Your name needs to appear as it is shown on your Professional License).
5. Hours of Operation: Mon-Fri 8-5 Sat 7-2
6. Please provide a list of services that will be provided.
7. **On initial application only**, submit a copy of the approval from the Office of Health Care Access to establish the clinic. Note: only those clinics which intend to provide primary care services are required to submit OHCA approval.

Jessica L. Wilson
 Signature of Administrator

5/15/09
 Date Signed



Phone: (860) 509-7444
 Telephone Device for the Deaf (860) 509-719
 410 Capitol Avenue - MS # 12HFL
 P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

ACORD™ CERTIFICATE OF LIABILITY INSURANCEDATE (MM/DD/YYYY)
02/27/09

PRODUCER

The NIA Group, LLC
One Executive Drive
P.O. Box 6728
Somerset, NJ 08875-6728

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE

NAIC #

INSURED

Humedco Corporation
500 Kings Highway North
Cherry Hill, NJ 08034

INSURER A: **Landmark American Insurance Company**

33138

INSURER B:

INSURER C:

INSURER D:

INSURER E:

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L LTR	INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
		GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$
		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN EA ACC AGG \$ AUTO ONLY: AGG \$
		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A		OTHER Professional Claims Made	LHM811197 \$50,000 Deductib	02/28/09	02/28/10	\$1,000,000 per claim \$3,000,000 Per Loc. Agg \$5,000,000 Policy Agg

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

** Supplemental Name **

Humedco Corporation
Atlanta Women's Medical Center, Inc.
Philadelphia Women's Center, Inc.
(See Attached Descriptions)

CERTIFICATE HOLDER

****Evidence of Insurance****

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE



DESCRIPTIONS (Continued from Page 1)

Cherry Hill Women's Center, Inc.
Hartford GYN Center
Northeast Women's Center, Inc.

Coverage: Dr. Twiddy - med mal while working for Humedco
Employed Physicians, Surgeons or Dentists Endorsement -
Professional services rendered on behalf of named insured NOT excluded for
Physician - Kenneth M. Twiddy, M.D retro date 08/15/06

Locum Tenens Insured:

Deborah Lyn Levich, M.D. - retro date 02/28/06
Gary Francis Nobert, M.D. - retro date 02/28/06
Karen L. Houch, M.D. - retro date 02/28/06
Stacey L. Jeronis, M.D. - retro date 02/28/06
Frederick James Rau, M.D. - retro date 02/28/06
Gerald Rehert MD - retro date 2/28/07
Adam L. Moises, M.D. - retro date 02/28/09
Richard M. Lieblich, M.D. - retro date 02/28/09
Carol Watson, M.D. - retro date 02/28/09
Matthew Saidel, M.D. - retro date 02/28/09
Ralph Laughingwell (Inactive) retro date 10/16/06
Steven L. Richman, D.O. (Inactive) - retro date 02/28/06
Mary S Blanks, M.D. (Inactive) - retro date 02/28/06
Chad Aaron Grotegut, M.D. (Inactive) - retro date 02/28/06
John Roizin, M.D. (Inactive) - retro date 02/28/06

Warranty : as a condition precedent to all coverage under this policy the insured will warrant that all Physicians, Surgeons, & Dentists will maintain on a continuous basis, subsequent to the effective date of this policy, their own Medical Malpractice Professional Liability Insurance coverage. Failure to maintain such coverage w/ limits of at least \$1M/\$3M shall result in the voiding of all insurance coverage under this policy. This DOES NOT apply to Doctors listed in Employed Physicians, Surgeons or Dentists Endorsement.

Coverage: Northeast Women's Center Retro Date 07/13/07 as inactive entity for past liability per sale contract

** Location Information**

Loc#1: 500 Kings Highway North, Cherry Hill, NJ 08034
Loc#2: 235 West Wieuca Road, Atlanta, GA 30342
Loc#3: 125 N 8th Street, Philadelphia, PA 19106
Loc#4: 502 Kings Highway North, Cherry Hill, NJ 08034
Loc#5: One Main Street, Unit N-1, Hartford, CT 06106
Loc#6: 2751 Comly Road, Philadelphia, PA 19154

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DIVISION OF HEALTH
SYSTEMS & SERVICES

IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

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DEPT OF PUBLIC HEALTH
DIVISION OF
STANDARD REGISTRATION

HARTFORD PHYSICIAN'S MGMT. CORP.

DBA HARTFORD GYN CENTER
ONE MAIN ST., UNIT N-1
HARTFORD, CT 06106

WACHOVIA BANK, N.A.
64-22-610

5/14/2009

PAY TO THE ORDER OF TREASURER, STATE OF CONNECTICUT

\$**1,000.00

One Thousand and 00/100***** DOLLARS

TREASURER, STATE OF CONNECTICUT
410 CAPITOL AVE. MS #12HSR
PO BOX 340308
HARTFORD, CT 06134

MEMO

Lic Ren

[Signature]
AUTHORIZED SIGNATURE

⑈00010192⑈ ⑆061000227⑆ 2000017122005⑈

10492

HARTFORD PHYSICIAN'S MGMT. CORP. - DBA HARTFORD GYN CENTER

TREASURER, STATE OF CONNECTICUT

Date 5/14/2009
Type Bill
Reference Lic Ren

Original Amt.
1,000.00

Balance Due
1,000.00

Check Amount

Payment
1,000.00
1,000.00

LIC 0009
DPH000111

Wachovia

Lic Ren

1,000.00

2009

Copy for
Licensee

DHSR #13a

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

Name and Address of Entity

Signature of DHSR Staff

Hartford Gyn Center

1 Main Street

Hartford, CT 06106

Jessie Burke, RNC

Licensure Category :

OPC

Licensed Capacity : _____

Census : _____

Licensed Capacity : _____

Census : _____

Date(s) of Onsite Inspection : 12/23/08

Date(s) Additional Information Obtained: _____

Personnel Contacted : Jessica Wilson, Administrator

REVIEW/FINDINGS/PROCESS (complete all applicable)

- ☒ Licensing Inspection: ☐ Initial ☒ Renewal ☐ Other: _____
- ☐ Revisit for the Purpose of _____
- ☒ See Complaint Investigation # 8354
- ☐ See Reportable Event Investigation # _____
- ☐ See Certification file.
- ☐ Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection.
See violation letter dated _____
- ☐ Citation # _____ was issued to this facility as a result of this inspection.
- ☒ Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection.
- ☐ Citation # _____ was verified as corrected. _____ was notified that the licensee was no longer required to post Citation (see narrative).
- ☐ Citation # _____ was not corrected (see narrative).
- ☒ Narrative Report / Additional Information Attached.
- ☐ Referral(s) to: _____

REPORT SUBMITTED BY

Jessie Burke, RNC

DATE OF REPORT

1/12/09

(✓) Approval for Issuance of License: *[Signature]* 1/13/09

2009



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Administrator
Hartford GYN Center
1 Main Street
Hartford, CT 06106

FROM: Rose McLellan
License and Application Supervisor
Facility License & Investigation Section

DATE: June 11, 2009

SUBJECT: Facility License

Enclosed is your license to operate an **Outpatient Clinic-Family Planning**

The license must be posted in a conspicuous place as required by the General Statutes of Connecticut Section 19-a-493.

The license is in effect only for the operation of the facility as it is now organized. It is not transferable to any other person, facility or address.

If we can be of any assistance, please do not hesitate to call the Licensure Processing Unit at (860) 509-7444.

RM/crj
Enclosure



Phone: (860) 509-7444
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HFL
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

To: Administrator
Hartford Gyn Center
1 Main Street
Hartford, CT 06106

From: Rose McLellan, License and Applications Supervisor

Date: April ²¹~~7~~, 2009

Subject: License Renewal Application Materials (Outpatient Clinic)

In accordance with Connecticut General Statutes, Section 19a-491(d), a licensing and inspection fee is required for the renewal of your facility's license. Acceptable forms of payment include a check, draft or money order made payable to the Treasurer, State of Connecticut. In order to avoid any processing delays, please attach checks, drafts or money orders directly to your renewal application.

The licensing and inspection fee required for the renewal of your facility's license is \$1,000.00, unless you are a non-profit corporation or municipality. The fee should be submitted prior to the issuance of your renewal license. The following reminders are offered:

1. Please type or print in black ink.
2. Please complete all applicable items.

Failure to comply with all informational requirements will necessitate returning the forms for correction, thereby delaying the issuance of your license. **Documents will be returned to the facility for correction only once.** The need for additional corrections will require an **office visit**.

The application materials must be completed within thirty (30) days. If for any reason the forms and/or fee cannot be submitted within this time frame, this office must be notified **in writing** of the reason for the delay. Please be aware that failure to submit application materials within thirty (30) days will delay the issuance of your license.

Please do not hesitate to contact the Licensure Processing Unit at (860) 509-7444 if you require clarification or any additional information.

RM/ng

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