

State of Kansas Medical Care Facility License

Facility: South Wind Women's Center, LLC

5107 East Kellogg Drive Wichita, Kansas 67218

County: Sedgwick

State ID: S-087-025

Is hereby granted a license by the Secretary of Health and Environment to conduct a medical care facility designated a

Ambulatory Surgery Center

This license is subject to the provisions of KSA 65-425 through 65-441 and unless sooner revoked or suspended for failure to comply with the requirements of said law, this license shall remain in effect upon filing by the agency of an annual report as prescribed.

Secretary of Health and Environment

/ State Fire Marshal Approved for Fire Safety

Kansas Department of Health and Environment Bureau of Community Health Systems Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, Kansas 66612-1365 Telephone: (785) 296-1200 Joyce Smith, Director Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365



Phone: 785-296-0131 Fax: 785-291-3419 jsmith@kdheks.gov www.kdheks.gov/bhfr/index.html

Robert Moser, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

July 31, 2014

South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, Kansas 67218

Re: Initial Kansas Ambulatory Surgery Center License

Kansas State ID No.: S-087-025

Dear Ms. Burkhart,

I am enclosing a medical care facility license which recognizes the South Wind Women's Center, LLC to be an ambulatory surgical center as defined at KAR 28-34-50 et seq., set forth by the State of Kansas with the effective date of July 25, 2014. This license will remain in effect upon filing the next annual report, 30 days prior to the effective month.

As an ambulatory surgical center, your facility is recognized as a medical care facility and must ensure compliance with provisions of the Kansas Risk Management Program. The facility risk management plan needs to be submitted to the risk management specialist in this office for approval. Should you have any questions related to risk management, you may contact Angela Jirik at (785) 291-3552 at any time.

As a medical care facility licensee, you will also need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility, the policy number for the coverage, and the effective date of the coverage. This information should be provided within the next 30 days.

Separate correspondence related to your designation as a Medicare certified ambulatory surgical center will be forwarded directly to you from the Centers for Medicare & Medicaid (CMS) Services regional office. If you have further questions or comments, please feel free to contact me.

Sincerely,

Joyce Smith, Director Health Facilities Program

Smith

Enclosure

□ Renewal	
☐ Change Owne	r

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT Bureau of Community Health Systems & Health Facilities Program Initial Application, Annual Report or Change of Ownership(s) LICENSE APPLICATION FOR MEDICAL CARE FACILITY

July 25 2014

DIVISION OF HEALTH

I.			CATION:		,				
A.	Class	ificatio	n of License Reque	sted: $\Box G$	eneral Hospital 🔼 🗛	SC	ss Hospital Spec	cial Hospital	ĺ
В.							1 10	nartai	trustwo
	C.	Facilit	y Address: 510	TER	ellogg Dr.	City			<u>,tal</u> 8
	D.	Chief	Executive Officer:	Julia	e A. Burkh	art Phone 3/6.4	25,3215 Fax	316.42	5,345
	**	CON	TROL AND COV	FDNINC	AUTHODITY				1
	Α -	Disclos	sing Entity's Name:	South	Wind Women	15 Ctr, Waddress	5107 E.K.	ellogg, h	Viclita
	В.	Type of	Entity 1. Sole Pro	oprietorshi	p 2. Partnership 1	3. Joint Venture □ 4.	Corporation for profit	5. Corpora	
	\(\) 6	Govern	nment - Type		7. Other (E	Explain)	8. Limit	ed Liability Co	mpany
				LOW WIT	THE INFORMATION	N AS FOLLOWS FOR	THE DISCLOSING	ENTITY LIST	FED ON
Do Not Write Below This Line Agency Use Only The part of the part		(in whole ector. ability for							
Γ		INI	DICATE WITH "X"		INDIVIDUAL NAME	1	DROGE	LXIV)	STATE
		DIRE	for for hip & labil labil % ow	ELE	(or Attachment)	l	EDICA - 0 2011	3	t
_			1	Do	Not Write Below This	Line Agency Use O	nly		
		e Date	July 25,		·	License ID No.	087-02	5	-

III. GENERAL INFORMATION: A. (FOR HOSPITALS ONLY) Number of Beds: general _____ long-term-care _____ bassinets List any other beds type and amount of beds licensed under this hospital license B. Number of Active Medical Staff C. Total Number of All Categories of Medical Staff D. Check the ONE box that applies: (initial application The applicant is licensed only The applicant is licensed and accredited The applicant is licensed, accredited and deemed to participate in Medicare by an approved П accrediting organization. Attach the current survey and the decision letter to this application. E. Indicate Accrediting Organization _____ and the expiration date ____ F. The licensing regulations include standards for optional organized services, departments, or units. Check those below that are provided by your facility. social services department surgery department □ occupational therapy department □ obstetrical department □ tuberculosis treatment pediatric department outpatient department alcoholism treatment ☐ intensive/coronary care units □ psychiatric department physical therapy department long-term care units radiology inhalation/respiratory therapy department □ dialysis G. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate or waiver? If yes, please attach copy a of the Certificate of Registration Contractor's CLIA number ____ \square NO The undersigned is authorized to represent the governing body, corporation, organization, individual, or partnership in whom is vested the responsibility for operation of the facility and certifies that the above information is true and correct, Signature Print Name Telephone Number

The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate this medical care facility is subject to provisions under the Kansas Law.

Return to: Kansas Department of Health and Environment Bureau of Community Health Systems

Health Facilities Program

1000 SW Jackson St. Suite 330

1000 SW Jackson St., Suite 330 Topeka, Kansas 66612

Phone Number (785) 296-1258

Fax Number (785) 291-3419

Search Results

Kansas State Board of Nursing - Official License Verification

License Number Search on 59351

Color Legend: The following colors are used to indicate license status.

ActiveInactiveLapsedExemptRevoked

Data last updated on Thursday, July 31, 2014 10:45:16

License Method:

14 - RN in Kansas: originally licensed from another state

License:

59351

Last Name:

Gomes

Middle Name:

First Name:

Elizabeth

IV Certified:

Professional

(RN) Registered Nurse

Description :
Original Issue Date :

10/24/1988

Expiration:

11/30/2014

Status:

, ,

Alert List:

Active

The <u>Kansas State Board of Nursing License Verification Page</u> is the official verification Web site of the <u>Kansas State Board of Nursing (http://www.ksbn.org/)</u>.

The <u>Kansas.gov (http://www.kansas.gov/)</u> Web site receives the license verification information directly from the Kansas State Board of Nursing database and is protected from alteration by unauthorized individuals by using encryption technology.

The Kansas State Board of Nursing License Verification System is considered a primary source for Kansas State Board of Nursing data. It is the same information the Kansas State Board of Nursing provides through other means and is true and complete to the best of our knowledge.

Each nurse record displayed on the Kansas State Board of Nursing License Verification System contains the date when the record was updated.

Lois Wilkins

From: Sent: To:	burkhart.julie@gmail.com on behalf of Julie Burkhart <jburkhart@itrustwomen.org> Thursday, July 31, 2014 11:29 AM Lois Wilkins</jburkhart@itrustwomen.org>
Subject:	Re: TW Board Members. One more question?
Lois,	
Thank you. I am not a nurse.	
Our Director of Nursing - Eliza	abeth Gomes is our RN/Risk Manager
KS License # 59351	
Please let me know if you need	l anything else. Julie
On Thu, Jul 31, 2014 at 11:09	AM, Lois Wilkins < <u>LWilkins@kdheks.gov</u> > wrote:
Ms. Burkhart,	
Are you a nurse? If not w credentials for our data b	whom shall I list as the RN/Risk Manager or someone with medical base?
Thank you,	
21100100 9000	



Thinking

Starting

Maintaining

Closing

Business Entity Search

Date: 07/31/2014

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary of State's office to ensure accurate information. When filing a Uniform Commercial Code statement on an entity, consult with your attorney to ensure the correct debtor name.

Business Summary

Current Entity Name

Business Entity ID Number

SOUTH WIND WOMEN'S CENTER LLC

File Name Change Online

6710966

View History and Documents

Current Mailing Address: Julie Burkhart - 5107 E Kellogg Dr, WICHITA, KS 67218 Update

Business Entity Type: KANSAS LTD LIABILITY COMPANY

Date of Formation in Kansas: 11/19/2012

State of Organization: KS

Current Status: ACTIVE AND IN GOOD STANDING

Certificate of Good Standing

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 6505 E CENTRAL AVE 112, WICHITA, KS 67206

Update Resident Agent/Office

Shows owner

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2013

Next Annual Report Due: 04/15/2015 File Online

Forfeiture Date: 07/15/2015

Close Your Business

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary



Thinking

Starting

Maintaining

Closing

Business Entity Search

Date: 07/31/2014

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Business Summary

Current Entity Name

Business Entity ID Number 4747515

TRUST WOMEN FOUNDATION INC.

File Name Change Online

View History and Documents

Current Mailing Address: JULIE BURKHART - 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Update

Business Entity Type: FOREIGN NOT FOR PROFIT

Date of Formation in Kansas: 08/30/2013

State of Organization: DC

Current Status: ACTIVE AND IN GOOD STANDING

Certificate of Good Standing

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Update Resident Agent/Office

Sake & Change

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 00/0000

Next Annual Report Due: 06/15/2015

File Online

Forfeiture Date: 09/15/2015

Close Your Business

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary

Trust Women Board Members

- Julie Burkhart, Wichita, KS CEO
 - o 161 S Belmont, Wichita, KS 67218
- Amber Lockner, Wichita, KS Treasurer
 - o PO Box 616, Perkins, OK 74059
- Tiffany Reynolds, Raleigh, NC
 - o 130 Sunstone Dr, Cary, NC 27519-7029
- Keith Sellers, Wichita, KS
 - o 161 S Belmont, Wichita, KS 67218
- Tanya Aziz, Wichita, KS Chair
 - o 1807 N Black Locust Ct, Andover, KS 67002-7552,
- Anthony Tenbrink, Wichita, KS
 - o 139 N Vine St, Wichita, KS 67203-5840
- Erin Kenny, Springfield, MO
 - o 1613 N Washington Ave, Springfield, MO 65803-2850
- Omare Ogisi
 - o 2019 W Ute St, Tulsa, OK 74127-2204

South Wind Women's Center – Questions for Medical Care Facility

- 1. Direct Ownership: Trust Women Foundation, Inc., 200 W. Douglas Ave., Suite 600, Wichita, KS 67202.
- 2. Mortgagor: Kellogg Investments, LLC holds the deed for the property.
- 3. Director/Officers: Non-applicable
- 4. Limited Liability: Trust Women Foundation, Inc. is the sole member of the limited liability company
- 5. Elected Officials: Non-applicable

Joyce Smith, Director Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365



Phone: 785-296-0131 Fax: 785-291-3419 jsmith@kdheks.gov www.kdheks.gov/bhfr/index.html

Susan Mosier, MD, Interim Secretary

Department of Health & Environment

Sam Brownback, Governor

June 18, 2015

South Wind Women's Center 5107 East Kellogg Drive Wichita, Kansas 67218

Medical Care Facility License Approval Letter for July 2015 Kansas State ID No.: S-087-025

Dear Ms. Burkhart,

Your application for the ambulatory surgery center has been received and approved for July 2015. The new effective dates will be from July 1, 2015 until July 1, 2016. I would suggest you maintain a copy of this letter for individuals requesting the effective dates of the ASC license.

As a medical care facility you will continue to be required to complete an annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law. A new license will be issued upon a change in the name on the face of the license or change in the address.

Your compliance with this licensing agency is appreciated. If my staff can be of any assistance to you, do not hesitate to contact our office.

Thank you,

Joyce Smith, Director Health Facilities Program

	nitial
BJF	Renewal
Ωс	hange Owner

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT Bureau of Community Health Systems & Health Facilities Program Initial Application, Annual Report or Change of Ownership(s) LICENSE APPLICATION FOR MEDICAL CARE FACILITY

	LI Cha	<u>L</u>	ICENSE	APPLICATION	FOR MEDICAL CAR	E FACILITY	
	DIVISI	ON OF HEALTH	τ .				rely
I.	IDENTI	FICATION:					
A.	Classifica	tion of License Requ	iested: 🗆	General Hospital	ASC	ospital Special Hos	spital
В.	Name of	Facility: SOUTH	NIND"	Women's Cen	TE/2 (Ema	il)	
	C. Faci	lity Address:510	1 E Ke	110gg Drive	city Wichita	zip <u>1</u> 072	18
	D. Chie	ef Executive Officer:	Julie	e Burkhart	Phone 310-425	3215 Fax 316-4	25-3451
		NTROL AND GOV	•	•			
	A. Discl	losing Entity's Name:	RUST V	MOMEN FOUNDATION	Address 5107	E Kewogg Dr Wich	nta, KS 672
	B. Type	of Entity 🛚 1. Sole F	roprietorshi	ip 🗆 2. Partnership (☐ 3. Joint Venture ☐ 4. Corpor		rporation t for profit
	□ 6. Gove	ernment - Type		7. Other	(Explain)	□ 8. Limited Liabili	ty Company
	COMPLE LINE A. A		LOW WI	THE INFORMATION	ON AS FOLLOWS FOR THE	DISCLOSING ENTITY	LISTED ON
2. 3. 4.	above. List each or in part; If the disc each 5 per If the disc	person who is the over by such facility or a closing entity is orga closing entity is orga recent owner, and for	wner (in whany of the prized as a nized as a all general	hole or in part) of any property or assets of si corporation, attach a li limited partnership or I partners.	mortgage, deed or trust, note out facility. ist showing the names and additionable limited liability company, please wing the names and addresses	or other obligation secu lress of each officer and ase describe each limite	red (in whole I director. Id liability for
	IN	DICATE WITH "X"	•	INDIVIDUAL NAME	ADDRESS	CITY	STATE
OWNER	2. MORTGAGOR 3. DIRECTOR/OFFICERS	4. LIMITED LIABILITY Describe, for each limited partnership & LLC the limited liability for each 5 % owner, and for all general partners.	S. ELECTED OFFICIALS	(or Attachment) Attachment	J	KDHE N 1 – 2015 acilities Program	
<u>~</u>	4 6	4. Q g iii a g	5.		Health I	acilities Program	
	1						
	<u> </u>		Do N	lot Write Below This	Line Agency Use Only		
		3					

Effective Date May 1, 2015

Renewal Date May 1, 2016

Approved By

A. (FOR HOSPITALS ONLY) Number of Beds: general _____ long-term-care ____ bassinets List any other beds type and amount of beds licensed under this hospital license B. Number of Active Medical Staff C. Total Number of All Categories of Medical Staff Check the ONE box that applies: D. The applicant is licensed only \Box The applicant is licensed and accredited The applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization. Attach the current survey and the decision letter to this application. E. Indicate Accrediting Organization and the expiration date F. The licensing regulations include standards for optional organized services, departments, or units. Check those below that are provided by your facility. ☐ Social services department Surgery department ☐ Occupational therapy department ☐ Obstetrical department ☐ Tuberculosis treatment ☐ Pediatric department Outpatient department ☐ Alcoholism treatment ☐ Intensive/coronary care units ☐ Psychiatric department ☐ Long-term care units ☐ Physical therapy department □ Radiology ☐ Inhalation/respiratory therapy department □ Dialysis G. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate or waiver? If yes, please attach copy a of the Certificate of Registration Contractor's CLIA number □ NO The undersigned is authorized to represent the governing body, corporation, organization, individual, or partnership in whom is yested the responsibility for operation of the facility and certifies that the above information is true and correct. Signature 316, 260.6939 Telephone Number The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate this medical care facility is subject to provisions under the Kansas Law. Kansas Department of Health and Environment Return to: Bureau of Community Health Systems Health Facilities Program

1000 SW Jackson St., Suite 330 Topeka, Kansas 66612

Fax Number (785) 291-3419

Phone Number (785) 296-1258

III. GENERAL INFORMATION:

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS

SOUTH WIND WOMEN'S CENTER 5107 EAST KELLOGG DRIVE WICHITA, KS 67218 CLIA ID NUMBER

17D2056639

EFFECTIVE DATE

11/12/2014

LABORATORY DIRECTOR

11/12/2014 EXPIRATION DATE

CHERYL CHASTINE MD DIRECTO

11/11/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Karen W. Dyer, Acting Director Division of Laboratory Services Survey and Certification Group Center for Clinical Standards and Quality

215 Certs2_051915

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)

EFFECTIVE DATE

LAB CERTIFICATION (CODE)

EFFECTIVE DATE

ABO & RH GROUP (510)

11/12/2014

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.



and change the world

TWF Board Members

Julie Burkhart – CEO 161 S Belmont Wichita, KS 67218

Anthony Tenbrink 139 N Vine St, Wichita, KS 67203-5840

Erin Kenny 1613 N Washington Ave. Springfield, MO 65803-2850

Omare Ogisi 2019 W Ute St. Tulsa, OK 74127

Beth Kanter 9811 Hill Street Kensington, MD 20895

Barbara Buff Apt 18C 345 E 86TH St New York, NY 10028-4752

Bruce Price, MD 19 Phillips Pond Rd Natick, MA 01760-5643

Keith Sellers 161 S Belmont Wichita, KS 67218





Business Entity Search

Date: 06/29/2016

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Business Summary

Current Entity Name

Business Entity ID Number

TRUST WOMEN FOUNDATION INC.

File Name Change Online

4747515
View History and Documents

Current Mailing Address: JULIE BURKHART - 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Update

Business Entity Type: FOREIGN NOT FOR PROFIT

Date of Formation in Kansas: 08/30/2013

State of Organization: DC

Current Status: ACTIVE AND IN GOOD STANDING

Certificate of Good Standing

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Update Resident Agent/Office

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2015

Next Annual Report Due: 06/15/2017 | File Online

Forfeiture Date: 09/15/2017

Close Your Business



Thinking

Starting

Maintaining

Closing

Business Entity Search

Date: 06/29/2016

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Business Summary

Current Entity Name

Business Entity ID Number

SOUTH WIND WOMEN'S CENTER LLC

File Name Change Online

6710966

View History and Documents

Current Mailing Address: Julie Burkhart - 5107 E Kellogg Dr, WICHITA, KS 67218

Business Entity Type: KANSAS LTD LIABILITY COMPANY

Date of Formation in Kansas: 11/19/2012

State of Organization: KS

Current Status: ACTIVE AND IN GOOD STANDING

Certificate of Good Standing

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 6505 E CENTRAL AVE 112, WICHITA, KS 67206

Update Resident Agent/Office

Annual Reports

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Tax Closing Month: 12

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Next Annual Report Due: 04/15/2017

File Online

Forfeiture Date: 07/15/2017

Close Your Business

Joyce Smith, Director Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365



Phone: 785-296-0131 Fax: 785-291-3419 jsmith@kdheks.gov www.kdheks.gov/bhfr/index.html

Susan Mosier, MD, Interim Secretary

Department of Health & Environment

Sam Brownback, Governor

May 1, 2015

Julie Burkhart, Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, Kansas 67218

Re: Hospitals and or Ambulatory Surgery Centers Annual Report

Dear Julie Burkhart,

The enclosed annual report form must be completed, signed and returned to our licensing agency within 30 days from the date on this letter. Retain a copy of this application for your facility files. Please mail this application and the appropriate documents to the address listed below.

If you have any questions, please contact Lois Wilkins at (785) 296-1258.

Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson Street, Suite 330 Topeka, KS 66612-1365

Thank you,

Joyce Smith, Director Health Facilities Program

Enclosure

Jim Perkins, Director Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365



jperkins@kdheks.gov Phone: 785-296-0131 Fax: 785-291-3419 www,kdheks.gov/bhfr/index.html

Department of Health & Environment

Sam Brownback, Governor

June 29, 2016

Susan Mosier, MD, Secretary

South Wind Women's Center 5107 East Kellogg Drive Wichita, Kansas 67218

Medical Care Facility License Approval Letter for July 2016 Kansas State ID No.: S-087-025

Dear Ms. Burkhart,

The Health Facilities Program has received the Medical Care Facility Annual Report for the Ambulatory Surgery Center. Your license application is approved for July 2016. The new effective dates are July 1, 2016 through July 1, 2017. Please maintain a copy of this letter for individuals who may request the effective dates of the ASC license.

As a medical care facility, you will continue to be required to complete an annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

Your compliance with this licensing agency is appreciated. If my staff can be of any assistance to you, do not hesitate to contact our office.

Thank you,

Jim Perkins, Director Health Facilities Program

☐ Initial	
Renewal	
☐ Change Owner	

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT Bureau of Community Health Systems & Health Facilities Program Initial Application, Annual Report or Change of Ownership(s) <u>LICENSE APPLICATION FOR MEDICAL CARE FACILITY</u>



DIVISION OF HEALTH

	DI V	10101	OF HEALTH								
I.	IDE	NTIFI	CATION:								
		ificatio		ted: [General Hospital	SC Critical Acc		pital OSpecial Hospin	al huindway		
Д.	C.	Facilit	cility Address: 507 E. Kellong Dr. City Willist Zip 67218 dief Executive Officer: The Bythat Phone 3/6,260,6334 Fax 3/6,425,345								
	H. CONTROL AND GOVERNING AUTHORITY A. Disclosing Entity's Name:										
	□6.0	Governi	ment - Type		□ 7. Other (E	Explain)		□ 8. Limited Liability	Company		
	COM		E THE BOXES BELO		TTH THE INFORMATIO						
2. 3. 4.	abov List or in If the If the each If the	each pe part) be disclosed disclosed 5 perced disclosed	erson who is the own by such facility or any osing entity is organizesing entity is organize ent owner, and for al	er (in y of th zed as zed as l gene	whole or in part) of any me property or assets of sur a corporation, attach a list a limited partnership or laral partners. tal unit, attach a list show	nortgage, deed or truch facility. t showing the name mited liability comp	ast, note of s and add pany, plea	or other obligation secur ress of each officer and ase describe each limited	ed (in whole director. I liability for		
		INDI	CATE WITH "X"		INDIVIDUAL NAME	ADDRESS		CITY	STATE		
	 Owner Mortgagor 	3. Director/Officers	4. Limited Liability Describe For Each Limited Partnership & LLC the Limited Liability For Each - 5 % Owner, and all General Partners.	5. Elected Officials	(or Attachment)		Health	KDHE UN 1 5 2016 Facilities Program			
		X	18 U		Affactorert	-					
		1	ar an in Secretary								
				12		for the second) i		
			* *					tin the district cary	- " "		
			1 20 2	D	o Not Write Below This	Line Agency Use (Only				
	ective I ewal D		7-1-20	01	<u>6</u> 17	License ID No	0 00	37025 LU	_		

III. G	ENERAL INFORMATION:	·
A	(FOR HOSPITALS ONLY) Number of Beds:	general long-term-care bassinets
	List any other beds type and amount of beds licer	nsed under this hospital license
В	. Number of Active Medical Staff	
C.	. Total Number of All Categories of Medical Staff	4
D	Check the ONE box that applies:	
	The applicant is licensed only The applicant is licensed and accredit The applicant is licensed, accredited accrediting organization. Attach the	ted and deemed to participate in Medicare by an approved current survey and the decision letter to this application.
E.	. Indicate Accrediting Organization	and the expiration date
F.	. The licensing regulations include standards for op Check those below that are provided by your faci	otional organized services, departments, or units. lity.
	Surgery department □ Obstetrical department □ Pediatric department Surpatient department □ Psychiatric department □ Physical therapy department □ Inhalation/respiratory therapy department □ Dialysis	 □ Social services department □ Occupational therapy department □ Tuberculosis treatment □ Alcoholism treatment □ Intensive/coronary care units □ Long-term care units □ Padialogy
G	Does this facility hold a valid Clinical Laboratory YES If yes, please attach copy a of the	Improvement Act (CLIA) certificate or waiver?
	☐ NO Contractor's CLIA number	
partin	pership in whom is vested the responsibility for operation is true and cornect.	ning body, corporation, organization, individual, or peration of the facility and certifies that the above July Print Name 3 July 25/6
Telepl	hone Number	Date
The un		lth and Environment for a license to operate this medical care facility
		rtment of Health and Environment
	Health F 1000 SW Ja	munity Health Systems acilities Program ckson St., Suite 330 , Kansas 66612

Thinking

Starting

Maintaining

Closing

Business Entity Search

Date: 06/17/2015

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary of State's office to ensure accurate information. When filing a Uniform Commercial Code statement on an entity, consult with your attorney to ensure the correct debtor name.

Business Summary

Current Entity Name

Business Entity ID Number

SOUTH WIND WOMEN'S CENTER LLC

File Name Change Online

6710966

View History and Documents

Current Mailing Address: Julie Burkhart - 5107 E Kellogg Dr, WICHITA, KS 67218

Update

Business Entity Type: KANSAS LTD LIABILITY COMPANY

Date of Formation in Kansas: 11/19/2012

State of Organization: KS

Current Status: ACTIVE AND IN GOOD STANDING

Certificate of Good Standing

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 6505 E CENTRAL AVE 112, WICHITA, KS 67206

Update Resident Agent/Office

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2014

Next Annual Report Due: 04/15/2016 File Online

Forfeiture Date: 07/15/2016

Close Your Business

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary



and change the world

TWF Board Members

Julie Burkhart - CEO 161 S Belmont Wichita, KS 67218

Anthony Tenbrink 139 N Vine St, Wichita, KS 67203-5840

Erin Kenny 1613 N Washington Ave. Springfield, MO 65803-2850

Omare Ogisi 2019 W Ute St. Tulsa, OK 74127

Beth Kanter 9811 Hill Street Kensington, MD 20895

Barbara Buff Apt 18C 345 E 86TH St New York, NY 10028-4752

Bruce Price, MD 19 Phillips Pond Rd Natick, MA 01760-5643

Keith Sellers 161 S Belmont Wichita, KS 67218

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS

SOUTH WIND WOMEN'S CENTÉR 5107 EAST KELLOGG DRIVE WICHITA, KS 67218 CLIA ID NUMBER

17D2056639

EFFECTIVE DATE

•

11/12/2014 EXPIRATION DATE

LABORATORY DIRECTOR

CHERYL CHASTINE MD DIRECTO

11/11/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Karen W. Dyer, Acting Director Division of Laboratory Services Survey and Certification Group Center for Clinical Standards and Quality

215 Certs2_051915

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)

EFFECTIVE DATE

LAB CERTIFICATION (CODE)

EFFECTIVE DATE

ABO & RH GROUP (510)

11/12/2014

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

OR UPDATE OF CERTIFICATION INFORMATION IN THE MEDICARE PROGRAM AMBULATORY SURGICAL CENTER REQUEST FOR INITIAL CERTIFICATION

(Please read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions for Coverage are met. Assistance in completing the form is available from the State agency. The ASC completes and signs this form for initial certifications and upon request of the State agency for the periodic recertification.

Answer all questions as of the current date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the appropriate Regional Office. Please see the following link for additional information: http://www.cms.gov/RegionalOffices/

Detailed instructions are given for questions other than those considered self-explanatory.

CMS Certification Number (CCN): Insert the facility's ten-digit CCN. Leave blank on initial requests for certification.

State/County and State Region Codes: The ASC leaves this blank.

Item III: If a service is provided directly by the facility, place a '1' in the appropriate block. If a service is provided under an arrangement with an outside source, place a '2' in the appropriate block. If the service is not provided, leave blank.

Item IV: Place an 'X' in the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one block may be checked.

Signature of Authorized Official sign in ink) (regulited only for initial destification **CMS Certification Number** APPLICABLE FEDERAL AND STATE LAWS. WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER II. TYPE OF CONTROL (Place '1' or '2' in blocks) SPO +80 CHARACTERISTICS (X appropriate blocks) I. IDENTIFYING INFORMATION III. ANCILLARY IV. SURGICAL SPECIALTIES V. FACILITY (Check one box) SERVICES AS7 AS6 Number of Operating Rooms/Procedure Rooms. Name of Facility City, County, and State マイナマ Endoscopy Ear/Nose/Throat Dental Proprietary Laboratory Nyth AS1 Wohler's State/County Code 4. Ob/Gyn Radiology Non-Profit → Orthopedic □ Ophthalmologic Pharmaceutical Services Government Street Address Plastic/reconstructive Pain Podiatry 2. Date Center Began Providing Services Zip Code State Region Code 10. | → Other(Specify) Telephone No. (Include Area Code 36. 460. Date June A510 AS9 AS4 ESA S

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is on the control number for this information collection is one of the control number. The valid OMB control number for this information collection is one of the control number. The valid OMB control number for this information collection is estimated to average 15 minutes per response, including the time to review instructions, searching information collection is one of the valid OMB control number. improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850 existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates(s) or suggestions for

Form CMS-377 (12/10)

Tho Over

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY ON BEHALF OF

Kansas Health Care Provider Insurance Availability Plan

August 21, 2015

USI Midwest Att: LaJeune Fitzpatrick 222 S. Riverside Plaza, Ste. 630 Chicago, IL 60606

Re:

Insured:

South Wind Women's Center

Policy No:

KSP0024050

Policy Period: 08/15/2015 to 08/15/2016

Dear Ms. Fitzpatrick:

Enclosed with this letter, please find the Kansas Availability Plan policy for the above-captioned insured. This policy is being forwarded to you as the agent of record on this account.

Please contact our office at 785/232-4740 if you have questions concerning this account.

Sincerely,

Sara Patry Underwriter

/sep

Enclosure

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY ON BEHALF OF THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN TOPEKA, KANSAS

HOSPITAL PROFESSIONAL LIABILITY PROGRAM Declarations-Claims Made

Item I. NAMED INSURED and Add				-		
F				7	Renews:	08/15/2016
South Wind Women's Center LL	С					
5107 E Kellogg Dr					The Named	Insured is:
Wichita, KS 67218					General (A	cute Care) Hospital
					Pediatric H	ospital 🗆
					Psychiatric	Hospital O
					Teaching as	nd/or Research 🗆
					Other (Spec	cify):
					Agent Nam	e & Address:
L				الـ	USI Midwe	est
					222 S Rive	rside Plaza
Item 2. Policy Period From	08/15/2015	to	08/15/2016		Chicago, Il	60606
.	12:01 A.M. stands	ırd time at t	he address of the Nam	ed Insured as sta	ted herein.	

Item 3. The Insurance afforded is only with respect to such of the following Coverage Parts and Coverages as are indicated by specific premium charge or charges. The limit of the Company's liability against each such Coverage shall be as stated herein, subject to all the terms of this policy having reference thereto.

COVERAGE PARTS	COVERAGES	LIMITS O	F LIABIL	ADVANCE PREMIUMS		
Hospital Professional	Retroactive Date: 08/15/2014	S	200,000	each claim	\$	6,000.00
•		\$	600,000	annual aggregate		
		\$		deductible		
	(I) Bodily Injury or Property Damage Liability	S		each occurrence		
Conuncreial General Liability Insurance					\$	
	(II) Personal Injury/Advertis- ing Injury Coverage	s		annual aggregate		
	Fire Legal Liability	\$		each occurrence		
		S		deductible		
Umbrella Liability	Retroactive Dute:	s		each claim		
					S	
		\$		annual aggregate		
		\$		deductible		
Excess Liability	Retroactive Date:	\$		each claim		
		s		annual aggregate	S	
		\$		deductible		
Endorsement Nos.	600 (ED 01/15), 604 (ED 01/15)					
	Total Deposit	Premium	s	6,000,00		

Item 1. NAMED INSURED and Address (No & Street, City, County State, Zip Code)	r	Policy N	umber:	CSP0024050
i r		٦	Renews:	08/15/2016
South Wind Women's Center LLC				
5107 E Kellogg Dr			The Named	Insured is:
Wichita, KS 67218			General (A	cute Care) Hospital 🛘
			Pediatric H	ospital 🖸
			Psychiatric	Hospital □
			Teaching ar	id/or Research 🛘
			Other (Spec	ify):
			Agent Nam	e & Address
L		ال	USI Midwe	st
_			222 S River	side Plaza
Item 2. Policy Period From 08/15/2015 to 08/15/2016			Chicago, II.	60606

Item 3. The Insurance afforded is only with respect to such of the following Coverage Parts and Coverages as are indicated by specific premium charge or charges. The limit of the Company's liability against each such Coverage shall be as stated herein, subject to all the terms of this pulicy having reference thereto.

12:01 A.M. standard time at the address of the Named insured as stated herein.

Countersigned by

Authorized Representative

KANSAS HEALTH CARE STABILIZATION FUND NOTICE OF BASIC COVERAGE FORM (May 2009)

Kansas law requires the Insurance Company to forward this completed form and HCSF surcharge payment to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the date the insurer receives the basic coverage premium. A copy of this completed form must also be furnished to the health care provider.

FOR HCSF USE ONLY

	dual Health Care Provide ler entity (professional asso							of the health car
lealth Care Provider's Name:	South Wind Women's C	•	•				•	
NOT NAME (OR FULL NAME OF HE RESIDENT	ALTH CARE PROVIDER ENTITY), FIRST NAME,					Daytime Phone Number		
City:						State:	2	ip:
lusiness Address of lealth Care Provider:	5407 E Mallana Da 1864							
Calul Care Florida.								
ECTION II Cove	rage Limit Selection - First	time Health Care Pr	rovider S	Signature	Required.			
\$100,0	000/\$300,000	× \$300,000/\$9	000,000			\$800,000/\$2,400,00	0	
Date Signed		Health Care Provide	e Clauntum		***			×
-	TS CANNOT BE INCREASE		-	INCREAS	ES MILIST	RE ADDROVED BY T	HE ROARD OF	
	RS. CONTACT THE HCSF					DE ATTROVED DT	IIL BOARD O	
	ance Policy Information narge Payment	And Health Care	Stabiliz	ation Fu	nd	For Fund Classes 1 to 14		or Fund ses 15 to 21
	Provider's License,	Basic	Num	ber of	HCSF	HCSF	O INC.	HCSF
HCSF Rate	Registration	Coverage		und	Class	Surcharge	HCSF	% Based
Classification Number	or Certification Premlum Co			oliance ears	Group No	Payment From Rate Tables	Surcharge Percent	Surcharge Payment
	800857801	6,000.00		2	17		35%	2,100.00
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, ,		**************************************		The publi	shed HCSF	surcharge for Fund clas	ses 1 to 15 was m	odified for the
	RE PROVIDER INSURANCE A	VAILABILITY PLAN			reason or re			
ENTER NAME OF INSURAN Sara Patry	CE COMPANY					SUBJECT TO A PART-1 APPROVED FOR USE B		CREDIT
•	NT OR COMPANY REPRESENTATIVE			PRO	FESSIONA	L LIABILITY INSURER.		FACTOR
					D WAS _			
(785) 232-4740						RESIDENT HEALTH CAP INSE AND THE 30% MC		
TELEPHONE NUMBER OF	NSURANCE AGENT OR COMPANY RE	PRESENTATIVE				HE ABOVE SURCHARD		
Policy Number:	KSP0024050				Туре	of Basic Coverage F	Professional Lia	
Inception Date:	08/15/2015						USE ONLY	
		CHAL LIABILITY INSURANCE POL	JCY PERIOD			101(1100)	000 0	
Coverage Effective D	ate: 08/15/2015							
1	ENTER DATE THIS HEALTH CARE PROVIDER V	VAS ADDED TO AH EXISTING POL	JCY PERIOD					
Expiration Date:	08/15/2016							
	OF THE BASIC PROFESS	ONAL LIABILITY INSURANCE POL	JCY PERIOD					
Kansas resident health c	ovider: If you should discontinus yo are provider, you should immodiatel Care Stabilization Fund's continuing	y contact the Kansas Hes	Ith Caro St	labilization Fu				
	F USE ONLY		water pre				FOR HOSE	USE ONLY
	•							
L						1		

Jim Perkins, Director Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365



jperkins@kdheks.gov Phone: 785-296-0131 Fax: 785-291-3419

www.kdheks.gov/bhfr/index.html

./Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

May 02, 2016

Julie Burkhart, Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, KS 67218

Re: Hospitals and or Ambulatory Surgery Centers Annual Report

Dear Julie Burkhart,

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter.

As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

Please return to Health Facilities Program the completed annual report, Hospital/CAH/ASC database worksheet, insurance declaration page along with all appropriate documentation for review.

Please retain the copies of these items for your facility files and mail the original documents to the address below. If you have any questions, please contact Lois Wilkins at (785) 296-1258.

Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson Street, Suite 330 Topeka, KS 66612-1365

Thank you,

Jim Perkins, Director Health Facilities Program

Enclosure

Jim Perkins, Director Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365



Jim.perkins@ks.gov Phone: 785-296-0131 Fax: 785-559-4250 www.kdheks.gov/bhfr/index.html

Susan Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

June 19, 2017

South Wind Women's Center 5107 East Kellogg Drive Wichita, Kansas 67218

Medical Care Facility License Approval Letter for July 2017 Kansas State ID No.: S-087-025

Dear Ms. Burkhart,

The Health Facilities Program has received the Medical Care Facility Annual Report for the Ambulatory Surgery Center. The license application is approved for July 2017. The ASC new effective dates are July 1, 2017 through July 1, 2018. Please maintain a copy of this letter for individuals who may request the effective dates of the ASC license.

As a medical care facility, you will continue to be required to complete an annual report each year.

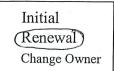
Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with Health Facilities Program during the annual renewal process and if our office can be of any assistance to you, do not hesitate to contact us.

Thank you,

Jim Perkins, Director Health Facilities Program



KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT Bureau of Community Health Systems & Health Facilities Program Initial Application, Annual Report or Change of Ownership(s) LICENSE APPLICATION FOR MEDICAL CARE FACILITY

	DIV	VISIC	ON OF HEALTH	[1 2 1 1			0	
I.	IDE	NTIF	FICATION:							
A.	Clas	sificat	ion of License Requ	iested:	General Hospital	ASC Critical Acce	ess Hospital	Special Hospita	1	
В.	Nan	ne of F	Facility: Suth	Wn	d women's	scenter	_ (Email) <u>ac</u>	omenscer	HV JOH	
	C.	Facil	ity Address: 510	116.	Kellogg DR	. City W	chita	Zip 107218		
1	D.	Chie	f Executive Officer	JUL	e BUVICHUY	Phone 310.	260.693	4 Fax 314:4	25.34	
II. CONTROL AND GOVERNING AUTHORITY								R. Blie	10	
	A.	Disclosing Entity's Name: TVUST WOMEN FOUNDATION Address SIONE Kellogg DR. Wichta, KS 67218								
	B.	Туре	of Entity 1. Sole P	roprietorsl	hip 2. Partnership	3. Joint Venture 4.	Corporation for p	profit (5. Corpora	ation r profit	
6. Government - Ty			nment - Type		7. Other ((Explain)	8	. Limited Liability C	Company	
2.3.4.	List abov List or in If th If th	the nave. each part) le disc	person who is the o by such facility or losing entity is orga losing entity is orga cent owner, and for	wner (in any of the inized as all gener	whole or in part) of any e property or assets of so a corporation, attach a la limited partnership or al partners. tal unit, attach a list sho	mortgage, deed or true uch facility. ist showing the names limited liability comp	st, note or other and address of any, please desc	each officer and deribe each limited	l (in whole irector.	
	INDICATE WITH "X"			114-22.5	INDIVIDUAL NAME	ADDRESS		CITY	STATE	
		ERS	LY.	VLS	(or Attachment)			Health To HUties Pr	10.00	
	OR	OFFIC	ABILT th limit LC the for t, and artners	FFICI/		*	•		ogram	
ER	MORTGAGOR	CTOR	ED LI for eac ip & L ability of owner neral p	(ED 0		estable site activities of the second	in a series	NAY 2 6 201	7	
1. OWNER	2. MOR	3. DIRECTOR/OFFICE	4. LIMITED LIABILIT Describe for each limite partnership & LLC the limited liability for each 5 % owner, and for all general partners.	5. ELECTED OFFICIAI		1		KDHE		
		X	Augresia Augres	1	attached.					
			Type of the transfer of	TEGT .		-1				
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				Do	Not Write Below This	I ino Agonay Use O	alw.			
			1 0		THE DELOW THIS					
Effec	ctive l	Date _	July 1,	271	1	License ID No.	50870	125		

Approved By_

III. GI	GENERAL INFORMATION:								
A.	A. (FOR HOSPITALS ONLY) Number of Beds: general	long-term-care bassinets							
	List any other beds type and amount of beds licensed under this hospital license B. Number of Active Medical Staff C. Total Number of All Categories of Medical Staff								
В.									
C.									
D.	Check the ONE box that applies:								
	o participate in Medicare by an approved ey and the decision letter to this application.								
E.	E. Indicate Accrediting Organizationa	nd the expiration date							
F.	F. The licensing regulations include standards for optional organized services, departments, or units. Check those below that are provided by your facility.								
The ur partne	□ Obstetrical department □ C □ Pediatric department □ T □ Outpatient department □ A □ Psychiatric department □ In □ Physical therapy department □ L □ Inhalation/respiratory therapy department □ R □ Dialysis G. Does this facility hold a valid Clinical Laboratory Improvement ■ YES If yes, please attach copy a of the Certificate o □ NO Contractor's CLIA number undersigned is authorized to represent the governing body, connership in whom is vested the responsibility for operation of the	f Registration rporation, organization, individual, or							
	ature Title	Julie A. Burkhart This Name To De							
Teleph	S(6, 400, 6) 59 phone Number Da	ate Cay Cay							
The und	undersigned hereby applies to the Kansas Department of Health and Environ ct to provisions under the Kansas Law.	ment for a license to operate this medical care facility is							
-	Return to: Kansas Department of Health and Environment Bureau of Community Health Systems								
	Health Facilities Program 1000 SW Jackson St., Suite 330								
F	Topeka, Kansas 66612 Phone Number (785) 296-1258	Fax Number (785) 291-3419							



Thinking

Starting

Maintaining

Closing

Business Entity Search

Date: 06/19/2017

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary of State's office to ensure accurate information. When filing a Uniform Commercial Code statement on an entity, consult with your attorney to ensure the correct debtor name.

Business Summary

Current Entity Name

TRUST WOMEN FOUNDATION INC.

File Name Change Online

Business Entity ID Number

4747515

View History and Documents

Current Mailing Address: JULIE BURKHART - 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218 Update

Business Entity Type: FOREIGN NOT FOR PROFIT

Date of Formation in Kansas: 08/30/2013

State of Organization: DC

Current Status: ACTIVE AND IN GOOD STANDING

Certificate of Good Standing

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Update Resident Agent/Office

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2016

Next Annual Report Due: 06/15/2018 File Online

Forfeiture Date: 09/15/2018

Close Your Business

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary of State's office to



Trust Women Foundation Board Members

Julie Burkhart- CEO 161 S. Belmont Wichita, KS 67218

Anthony Tenbrink 139 N. Vine St. Wichita, KS 67203-5840

Erin Kenny 1613 N. Washington Ave. Springfield, MO 65803-2850

Omare Ogisi 2019 W. Ute St. Tulsa, OK 74127

Beth Kanter 9811 Hill Street Kensington, MD 20895

Barbara Buff APT 18C 345 E. 85th St. New York, NY 10028-4752

Bruce Price, MD 19 Phillips Pond Rd Natick, MA 01760-5643

Keith Sellers 161 S. Belmont Wichita, KS 67218

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS SOUTH WIND WOMEN'S CENTER 5107 EAST KELLOGG DRIVE WICHITA, KS 67218 CLIA ID NUMBER 17D2056639

EFFECTIVE DATE

11/12/2016

EXPIRATION DATE

11/11/2018

LABORATORY DIRECTOR

LESLIE F PAGE DO DIRECTOR

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS

Karen W. Dyer, Acting Director Division of Laboratory Services Survey and Certification Group Center for Clinical Standards and Quality

220 Certs2_101816

Oke

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)
ABO & RH GROUP (510)

EFFECTIVE DATE

LAB CERTIFICATION (CODE)

EFFECTIVE DATE

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current

source, place a '2' on the appropriate line. If the service is not provided, leave blank. Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside

(i.e., not subspecialties). More than one service may be selected. Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories

Name of Facility		CMS Certification Number St	State ID Number	County
SOLYN WINCH WOMEN'S CENTER	n's center	2056639	s-887.825	Sections
	Street Address; City and Zip code:	Zip code:		Telephone No. (Include Area Code)
identifying Information	SIOT E. KELL	E. KENDOJO DP. WICHTH I	217LM SX	3/6.260.6934
Type of Control	1. Proprietary		4	
Select one	2. Non-Profit		ŧ	
Ancillary Services Select 1 or 2	1. Laboratory	2. Radiology	3. Pharmaceutical Services	al Services
Surgical Specialties	1. Dental 2. End	2. Endoscopy 3. Ear/Nose/Throat	4. Ob/Gyn _	5. Ophthalmologic
	6. Orthopedic	7. Pain 8. Plastic/Reconstructive	uctive 9. Podiatry	itry 10. Other (specify)
Facility Characteristics	Number of Operating Ro	Number of Operating Rooms/Procedures Rooms $ 2 $	_ Date Cent	Date Center Began Providing Service $1/25/14$
Pint Name of Authorized Official Julie 4 Swither	+	Title		Date 23 May 2017
Signature				0

Jim Perkins, Director Health Facilities Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365



jperkins@kdheks.gov Phone: 785-296-0131 Fax: 785-296-3419 www.kdheks.gov/bhfr/index.html

Susan Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

May 01, 2017

Julie Burkhart, Administrator South Wind Women'S Center, Llc 5107 East Kellogg Drive Wichita, KS 67218

Re: Hospitals and or Ambulatory Surgery Centers Annual Report

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As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

Please return to Health Facilities Program the completed annual report, Hospital/CAH/ASC database worksheet, insurance declaration page along with all appropriate documentation for review.

Please retain the copies of these items for your facility files and mail the original documents to the address below. If you have any questions, please contact Lois Wilkins at (785) 296-1258.

Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson Street, Suite 330 Topeka, KS 66612-1365

Thank you,

Jim Perkins, Director Health Facilities Program

Enclosure

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT DIVISION OF PUBLIC HEALTH CURTIS STATE OFFICE BUILDING 1000 SW JACKSON ST., SUITE 330 TOPEKA, KS 66612-1365



Phone: (785) 296-0127 Fax: (785) 559-4250 www.kdheks.gov/bher

June 19, 2018

South Wind Women's Center 5107 East Kellogg Drive Wichita, Kansas 67218

Medical Care Facility License Approval Letter for July 2018 Facility State ID Number: S-087-025

Dear Ms. Burkhart,

The Health Facilities Program has received the Medical Care Facility Annual Report for the Ambulatory Surgery Center. The state agency reviewed and revised our records for July 2018. The ASC's new effective dates are July 1, 2018 through July 1, 2019. Please maintain a copy of the letter for individuals who may request the effective dates of this ASC's license.

As a medical care facility, you will continue to be required to complete an annual renewal report each year with the state agency.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

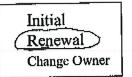
A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with Health Facilities Program during the annual renewal process and if our office can be of any assistance to you, do not hesitate to contact us.

Thank you,

Jim Perkins, Director Health Facilities Program Jim.Perkins@ks.gov

Ph: 785-296-0131 Fax: 785-559-4250



IDENTIFICATION:

Renewal Date ____

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT Bureau of Community Health Systems & Health Facilities Program Initial Application, Annual Report or Change of Ownership(s) LICENSE APPLICATION FOR MEDICAL CARE FACILITY



DIVISION OF HEALTH

Women's Cent	ـــــــــــــــــــــــــــــــــــــ	yr d - 3 ã	
11099 Drive	city Wichita	zip_ <u>67</u> 2	218
Buckhart	Phone 316 425 321	5 Fax 316 C	<u> 125 3451</u>
AUTHORITY			
Women foun	<u>dation</u> Address <u>5107</u> &	Kelloga Dr1	Nichota KS
p 2. Partnership 3.	Joint Venture 4. Corporation for	or profit /5. Corp	oration oration for profit
7. Other (Ex	plain)	8. Limited Liabilit	y Company
whole or in part) of any moreoperty or assets of such corporation, attach a list limited partnership or lingle partners.	ortgage, deed or trust, note or ot h facility. showing the names and address nited liability company, please o	her obligation secu of each officer and describe each limit	ared (in whole d director. ed liability for
(or Attachment)	KDHE MAY - 4 2018 Health Facilities Program		
Attachment	figured it is a settler of the settle in the		The standard of the standard o
o Not Write Below This	Line Agency Use Only		-
	License ID No.	7925	
	Momen's Center 11099 Dr. Je E Buckhart AUTHORITY Women Found p 2. Partnership 3. 7. Other (Extended the components) of any mean property or assets of such corporation, attach a list all partners. all unit, attach a list showing in the components of a list showing in the compo	AUTHORITY Department Phone 316 425 321 AUTHORITY Worker Foundation Address 5107 E p 2. Partnership 3. Joint Venture 4. Corporation for 7. Other (Explain)	P 2. Partnership 3. Joint Venture 4. Corporation for profit 5. Corporation for profit 7. Other (Explain) 8. Limited Liability Presson who has any direct or indirect ownership of 5 percent or more in enterproperty or assets of such facility. Corporation, attach a list showing the names and address of each officer and limited partnership or limited liability company, please describe each limited all partners. INDIVIDUAL NAME ADDRESS CITY WAY -4 2018 Health Facilities Program Not Write Below This Line Agency Use Only License ID No.



Business Entity Search

Date: 06/19/2018

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary of State's office to ensure accurate information. When filing a Uniform Commercial Code statement on an entity, consult with your attorney to ensure the correct debtor name.

Business Summary

Current Entity Name

Business Entity ID Number

TRUST WOMEN FOUNDATION INC.

4747515

Current Mailing Address: JULIE BURKHART - 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Business Entity Type: FOREIGN NOT FOR PROFIT

Date of Formation in Kansas: 08/30/2013

State of Organization: DC

Current Status: ACTIVE AND IN GOOD STANDING

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2017

Next Annual Report Due: 06/15/2019

Forfeiture Date: 09/15/2019



and change the world

TWF Board Members

Julie Burkhart - CEO 161 S Belmont Wichita, KS 67218

Anthony Tenbrink 139 N Vine St, Wichita, KS 67203-5840

Erin Kenny 1613 N Washington Ave. Springfield, MO 65803-2850

Omare Ogisi 2019 W Ute St. Tulsa, OK 74127

Beth Kanter 9811 Hill Street Kensington, MD 20895

Barbara Buff Apt 18C . 345 E 86TH St New York, NY 10028-4752

Bruce Price, MD 19 Phillips Pond Rd Natick, MA 01760-5643

Keith Sellers 161 S Belmont Wichita, KS 67218

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS SOUTH WIND WOMEN'S CENTER 5107 EAST KELLOGG DRIVE WICHITA, KS 67218 CIJA ID NUMBER 17D2056639

EFFECTIVE DATE

11/12/2016

LABORATORY DIRECTOR

LESLIE F PAGE DO DIRECTOR

EXPIRATION DATE

11/11/2018

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Karch W. Dyer, Acting Director Division of Laboratory Services Survey and Certification Group

Center for Clinical Standards and Quality

220 Corts2 101816

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE) ABO & RH GROUP (510)

EFFECTIVE DATE 11/12/2014 LAB CERTIFICATION (CODE)

EFFECTIVE DATE

TTT.	GI	ENERAL INFORMATION:
	Α.	(FOR HOSPITALS ONLY) Number of Beds: general long-term-care bassinets
		List any other beds type and amount of beds licensed under this hospital license
	в.	Number of Active Medical Staff
	C.	Total Number of All Categories of Medical Staff
	D.	Check the ONE box that applies:
		 ☐ The applicant is licensed only ☐ The applicant is licensed and accredited ☐ The applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization. Attach the current survey and the decision letter to this application.
~ ·	E.	Indicate Accrediting Organization and the expiration date
		The licensing regulations include standards for optional organized services, departments, or units. Check those below that are provided by your facility.
		□ Surgery department □ Social services department □ Obstetrical department □ Occupational therapy department □ Pediatric department □ Tuberculosis treatment □ Outpatient department □ Alcoholism treatment □ Psychiatric department □ Intensive/coronary care units □ Physical therapy department □ Long-term care units □ Inhalation/respiratory therapy department □ Radiology
(J	Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate or waiver?
		YES If yes, please attach copy a of the Certificate of Registration
		□ NO Contractor's CLIA number
ifor	ıer:	dersigned is authorized to represent the governing body, corporation, organization, individual, or whom is vested the responsibility for operation of the facility and certifies that the above tion is true and correct.
3/1	P	Title Julis A Burkhart Print Name 4 May 2018

The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate this medical care facility is subject to provisions under the Kansas Law.

Return to: Kansas Department of Health and Environment

Bureau of Community Health Systems

Health Facilities Program 1000 SW Jackson St., Suite 330 Topcka, Kansas 66612

Phone Number (785) 296-1258

Fax Number (785) 559-4250

Telephone Number

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

e ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current

m III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside am IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories arce, place a '2' on the appropriate line. *If the service is not provided at this ASC enter WA, please do not leave any blank spaces on this form. 2, not subspecialties). More than one service may be selected.

ne of Facility		CMS Certification Number	State ID Number	County
Such Whole to money's Centur	is Center	17-	\$-08702S) Seda wick
	Street Address; City and Zip code:	Zip code:		Telephone No. (Include Area Code)
stifying Information	SIOT E Kellag	DO Orive Wichith 67218	67518	316 260 6934
e af Control :ct one	1. Proprietary 2. Non-Profit 3. Government			
illary Services et 1 or 2 N/A	1. Laboratory	2. Radiology	3. Pharmace	3. Pharmaceutical Services
gical Specialties	1. Dental 2. End	2. Endoscopy 3. Ear/Nose/Throat	oat 4. Ob/Gyn _	m / 5. Ophthalmologic
straphoduate selections	6. Orthopedic	7. Pain 8. Plastic/Reconstructive		9. Podiatry 10. Other (Specify)
lity Characteristics	Number of Operating Rooms	oms/Procedures Rooms 2	Date C	Date Center Began Providing Service $4 3 3 3$
Name of Authorized Official		Title		Date

Flip this Page for Part II

ard Pourcies

Revised by HFP 3.2018

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

CERTIFICATE OF INSURANCE

POLICY NUMBER: KSP	0024050		POLICY HOLDER SINCE:	08/15/2014
FOR THE PERIOD FROM	08/15/2017	 12:01a.m.	TO 08/15/2018	12:01 a.m.
FOR THE PERIOD FROM	08/13/2017	12.014.111.	10 00/13/2010	
	NAME A	AND ADDRESS OF CER	TIFICATE HOLDER:	
	NAME AN	ID ADDRESS OF HEALT	TH CARE PROVIDERS:	
South Wind Women's Center		D ADDRESS OF HEALT	TI CARE I NO VIDENS.	
5107 E Kellogg Dr	LLC			
Wichita, KS 67218				
named above for the poterms, exclusions, and conc Fund (HCSF) are based u	olicy period indicated. The ditions of such profession	e insurance afforded by al liability policy. The	above has been issued to the the policy described herei limits of liability for the Fare Provider as shown in the	n is subject to all the lealth Care Stabilization
the date of issuance of this C		LIMITS OF LIABILIT	Y	
the date of issuance of this C		CIMITS OF CIADICIT	_	
the date of issuance of this C	КНСРІАР	HCSF Option	2	TOTAL
Each Claim	KHCPIAP \$200,000			\$500,000
		HCSF Option		
Each Claim	\$200,000	HCSF Option \$300,000		\$500,000
Each Claim	\$200,000	HCSF Option \$300,000		\$500,000
Each Claim	\$200,000	HCSF Option \$300,000		\$500,000
Each Claim Annual Aggregate	\$200,000 \$600,000	HCSF Option \$300,000		\$500,000
Each Claim	\$200,000 \$600,000	HCSF Option \$300,000		\$500,000

DEPARTMENT OF HEALTH AND ENVIRONMENT DIVISION OF PUBLIC HEALTH CURTIS STATE OFFICE BUILDING 1000 SW JACKSON ST., SUITE 330 TOPEKA, KS 66612-1365



PHONE: (785) 296-0127 FAX: (785) 559-4250 WWW.KDHEKS.GOV

GOVERNOR JEFF COLYER, M.D. JEFF ANDERSEN, ACTING SECRETARY

April 05, 2018

Julie Burkhart, Administrator South Wind Women'S Center, Llc 5107 East Kellogg Drive Wichita, KS 67218

Re: Hospitals and or Ambulatory Surgery Centers Annual Report

Dear Julie Burkhart,

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter.

As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

In accordance with KSA 65-4922. Medical care facilities; risk management program required; submission of plan; inspections and investigations; approval of plan; reports and records confidential; KAR 28-52-1. General requirements, the Risk Management Plan (RMP) is also which requires all medical care facilities licensed by the Kansas Department of Health and Environment submitted for review to the KDHE Risk Manager no later than 60 days prior to the renewal of the medical care facility licensure. The preferred timeframe is 90 days as the RMP must be approved prior to the renewal of the medical care facility licensure.

Please return to Health Facilities Program the completed annual report, Hospital/CAH/ASC database worksheet, insurance declaration page along with all appropriate documentation for review.

Please retain the copies of these items for your facility files and mail the original documents to the address below. If you have any questions, please contact Lois Wilkins at (785) 296-1258.

Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson Street, Suite 330 Topeka, KS 66612-1365

Thank you,

Jim Perkins, Director Health Facilities Program

Enclosure

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1365



Phone: 785-296-0127 Fax: 785-559-4250 www.kdheks.gov/bh/r

Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

June 21, 2019

South Wind Women's Center 5107 East Kellogg Drive Wichita, Kansas 67218

Re: Medical Care Facility License Approval for July 2019 Ambulatory Surgery Center Facility State I.D. Number: S-078-025

Dear Julie Burkhart,

The Kansas Department of Health and Environment/ Health Facilities Program received the Medical Care Facility Annual Report for the Ambulatory Surgery Center. The state agency has amended or records according to the ASC licensure application for July 2019. The ASC new effective dates are July 1, 2019 through July 1, 2020. Please maintain a copy of this letter for individuals who may request the effective dates of this ASC license.

As a medical care facility, you will continue to be required to complete an annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with Health Facilities Program during the annual renewal process and if our office can be of any assistance to you, do not hesitate to contact us.

Thank you,

Marílyn St Peter

Marilyn St Peter, RN, Director Health Facilities Program Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson St. Ste. 330 Topeka, KS 66612 Marilyn.St.Peter@ks.gov



Page 2

Kansas Department of Health and Environment

Bureau of Community Health Systems & Health Facilities Program

Medical Care Facility Licensure Application Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:
A. Classification of License select one: General Hospital Critical Access Hospital Special Hospital Ambulatory Surgery Center
B. Name of Medical Care Facility: South Wind Women's Certific Address: 5107 EKELLOGA Drive City: Wichita Zip Code: 67218 Public Phone: 316 2606934 Fax: 316 42532 Web Address: WWW. Trustwomen. org
* Ambulatory Surgery Centers List Days and Hours of Operations for this ASC: Days Open: M — F Operation Hours: 8-5 Health Facilities Program MAY 2 9 2019
Administration Information: C. Chief Executive Officer: Juli & Burkhart
Desk phone 316 425 3215 Email address Jhurthart @itrustwomen. DRG * Chief of Medical Staff: Coll EEN MCN, Cholas
* Director or Risk Manager Name: Christie Burlhart
Email address: CoulthartCi trustus MPhone: 316 425 3215 Do Not Write Below This Line, State Agency Use Only One of The State Agency Use Only
Renewal Date Luly 25, 2019 Facility I.D. Number S 0 8 7 0 2 5 Reviewed By

Ownership Information:

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

- 1. List the name(s) and addresses of each person who has any direct or indirect ownership of 5 percent or more in this entity.
- 2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- 3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.
- 4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
- 5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

II. CONTROL AND GOVERNING AUTHORITY:

A. Disclosing Entity's Name	: Trust Nom	en foundation	
Physical Address: 510			
B. Type of Entity: Corp	ooration for profit	Corporation non-pr	ofit
Limited Liability	y Company (LLC)	Professional Associ	ates (P.A.)
Government/County		Other (Explain)	
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address



Business Entity Search

Date: 06/03/2019

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Business Summary

Current Entity Name

Business Entity ID Number

TRUST WOMEN FOUNDATION INC.

4747515

Current Mailing Address: JULIE BURKHART - 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Business Entity Type: FOREIGN NOT FOR PROFIT

Date of Formation in Kansas: 08/30/2013

State of Organization: DC

Current Status: ACTIVE AND IN GOOD STANDING

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

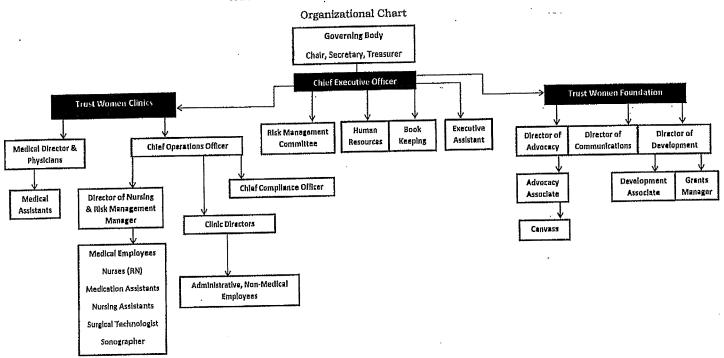
Tax Closing Month: 12

The Last Annual Report on File: 12/2018

Next Annual Report Due: 06/15/2020

Forfeiture Date: 09/15/2020

Trust Women Foundation & Trust Women Clinics





Board of Directors

Julie A. Burkhart- CEO 161 S Belmont Street Wichita, KS 67218

Anthony Tenbrink 139 N Vine Street Wichita, KS 67203

Erin Kenny 1613 N Washington Avenue Springfield, MO 65803

Omare Ogisi 2019 W Ute St. Tulsa, OK 74127

Beth Kanter 9811 Hill Street Kensington, MD 20895

Barbara Buff Apt 18C 345 E 86th St New York, NY 10028

Bruce Price, MD 19 Phillips Pond Rd Natick, MA 01760

Keith Sellers 161 S Belmont Wichita, KS 67218

`	General Inj	formation:				
A	. (FOR HOSF	PITALS ONLY) N	ımber of Beds:	General beds _	Observation beds	
	Swing beds	s IPPS	beds	LTC	Bassinets	
В	. Number of A	Active Medical Sta	ff <u>4</u>			
C	. Check the	box that applies:				
	☐ This ☐ This	applicant is license applicant is license applicant is license ag organization.	ed, accredited	nd deemed to pa	rticipate in Medicare by an a	pproved
D	Specify the A organization	screditing Organi full survey with th	zation e decision lette	r,	and provide the current	accrediting
	Provide the a	ccreditation effect	ve dates		Committee of the Commit	
	*Submit copy	of the (MCF) Cer	tificate of Prof	essional Liability	Insurance i.e., the Declarati	on Letter.
E.	Check the box		provided by yo	ur facility. * Ple	ted services, departments, or ase submit the completed hos	
	□ 0 >> 0 □ Pe □ Le	urgery department bstetrical departme utpatient departmen ediatric departmen ong Term Care Un tensive coronary c adiology	nt t ` it	C Occuj	iatric Services	
F.		lity hold a valid Ca ase submit copy a			Act (CLIA) certificate of Registration.	
		ip in whom is vested			ng body, corporation, organizat f the facility and certifies that th	
I unders	tand that this appl	ication may be subjec	t to release pursua	nt to the Kansas Op	n Records Act (K.S.A. 45-215 et	seq.).
Pho The under	nt Name L 425 one number rrsigned hereby appl s under the Kansas	Title 3215 ies to the Kansas Depart	Ment of Health and	Signature Date Environment for a lice	mse to operate this medical care facility	y is subject to
Return c	ompleted applicat	ion & documentation:		ent of Health and En nmunity Health Sys		
			Health Fa 1000 SW Ja	ncilities Program ckson St., Suite 33		
Phon	ie Number (785) 2	96-1258		Kansas 66612 is.wilkins@ks.gov	Fax Number (785) 5.	59-4250

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current

Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside source, place a '2' on the appropriate line. If the service is not provided, leave blank.

Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one service may be selected.

Nome of Tability	
South wind Women's Centure 17-	rtification Number State ID Number S-08705
Identifying Information	JI Cac Driv
Type of Control Select one	
Ancillary Services Select 1 or 2	1. Laboratory 2. Radiology 3. Pharmaceutical Services
Surgical Specialties Select appropriate selections	1. Dental 2. Endoscopy 3. Ear/Nose/Throat 4. Ob/Gyn X 5. Ophthalmologic 6. Orthopedic 7. Pain 8. Plastic/Reconstructive 9. Podiatry 10. Other (Specify)
Facility Characteristics	Number of Operating Rooms/Procedures Rooms 2 Date Center Began Providing Service 4320(3
Pint Name of Authorized Official Signature	Dete Date Date AS/ May 2019

Revised by HFP 6.2016

Flip this Page for Part II

AMBULATORY SURGICAL CENTER SURVEY REPORT CRUCIAL DATA EXTRACT

		YES	NO
	1. Emergency Call Lights	7	
2.	2. Oxygen	7	
3.	3. Mechanical ventilatory assistance equipment		
4.	4. Cardiac defibrillator	7	
5.	5. Cardiac monitoring equipment		
6.	6. Tracheostomy set		
7.	7. Laryngoscopes and endotracheal tubes		
∞:	Suction equipment	>	
9.	9. Emergency medical equipment & supplies	7	
	And the second s		

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

CERTIFICATE OF INSURANCE

POLICY NUMBER: KSPO	0024050		POLICY HOLDER SINCE:	08/15/2014
FOR THE PERIOD FROM	08/15/2018	12:01a.m.	TO 08/15/2019	12:01 a.m.
	NAME A	ND ADDRESS OF CE	RTIFICATE HOLDER:	
	NAME AN	D ADDRESS OF HEAT	LTH CARE PROVIDERS:	
South Wind Women's Center 5107 E Kellogg Dr	LLC			
Wichita, KS 67218				
This is to certify that the named above for the potents, exclusions, and conterms, exclusions, and conterms.	licy period indicated. Th onditions of such profe) are based upon the	e insurance afforded ssional liability polic limits option selected	above has been issued to the by the policy described hereity. The limits of liability do by the Health Care Provi	n is subject to all t for the Health Ca
Wichita, KS 67218 This is to certify that the named above for the poterms, exclusions, and contabilization Fund (HCSF)	licy period indicated. Th onditions of such profe) are based upon the	e insurance afforded ssional liability polic limits option selected	by the policy described herei by. The limits of liability if by the Health Care Provi	n is subject to all t for the Health Ca
Wichita, KS 67218 This is to certify that the named above for the poterms, exclusions, and control of the stabilization of the control of the control of the stabilization of the control of the stabilization of the stab	licy period indicated. Th onditions of such profe) are based upon the	e insurance afforded ssional liability polic limits option selected ate of Insurance.	by the policy described herei by. The limits of liability d by the Health Care Provi	n is subject to all t for the Health Ca
Wichita, KS 67218 This is to certify that the named above for the poterms, exclusions, and constabilization Fund (HCSF) company's records at the date	licy period indicated. The onditions of such profe are based upon the coffissuance of this Certific	e insurance afforded ssional liability police limits option selected ate of Insurance. LIMITS OF LIABIL	by the policy described herei by. The limits of liability d by the Health Care Provi	n is subject to all t for the Health Ca ider as shown in t
Wichita, KS 67218 This is to certify that the named above for the poterms, exclusions, and contabilization Fund (HCSF)	licy period indicated. The onditions of such profe are based upon the of issuance of this Certific KHCPIAP	e insurance afforded ssional liability police limits option selected ate of Insurance. LIMITS OF LIABIL HCSF Option	by the policy described hereicy. The limits of liability if the Health Care Provi	n is subject to all t for the Health Ca ider as shown in t TOTAL
Wichita, KS 67218 This is to certify that the named above for the poerms, exclusions, and constabilization Fund (HCSF) company's records at the date	licy period indicated. The onditions of such profe are based upon the offissuance of this Certific KHCPIAP \$200,000	e insurance afforded ssional liability police limits option selected ate of Insurance. LIMITS OF LIABIL HCSF Option \$300,000	by the policy described hereicy. The limits of liability if the Health Care Provi	n is subject to all to for the Health Calider as shown in the TOTAL \$500,000
Wichita, KS 67218 This is to certify that the named above for the poerms, exclusions, and constabilization Fund (HCSF) company's records at the date	licy period indicated. The onditions of such profe are based upon the offissuance of this Certific KHCPIAP \$200,000	e insurance afforded ssional liability police limits option selected ate of Insurance. LIMITS OF LIABIL HCSF Option \$300,000	by the policy described hereicy. The limits of liability if the Health Care Provi	n is subject to all to for the Health Calider as shown in the TOTAL \$500,000

INSURED COPY

HOSPITAL PROFESSIONAL LIABILITY PROGRAM Declarations-Claims Made

tiem 1 NAMED INSURED and	Address (No. & Street, City, County State, Zi	p Code)		Policy Number:	KS	P0024050		
F				T Rene	ows:	08/15/2019		
South Wind Women's Center LLC 5107 E Kollogg Dr Wichita, KS 67218		08/15/2019 address of the Named Insured		The Named Insured is: General (Acute Care) Hos Pediatric Hospital Psychiatric Hospital Teaching and/or Research Other (Specify): Agent Name & Address; USI Midwest 222 S Riverside Plaza Chicago, IL 60606 red as stated herein.		te Care) Hospital pitul ospital for Research y): Address: de Plaza 60606	e indicated by specific promium	
having reference thereto. COVERAGE PARTS	COVERAGES	LIMITS	OF LIABIL	ITY	F	ADVANCE PREMIUMS		
Hospital Professional	Retronctive Date: 08/15/2014	\$	200,000	each claim		6,000.00		
Liability Insurance		\$	600,000	annual aggregate		•		
		\$		deductible				
	(I) Bodily lujury or Property Damage Liability	\$		each occurrence				
Commercial General Liability Insurance					5	3		
Elebrity Institution	(11) Personal Injury/Advertis- ing Injury Coverage	\$		amual aggregate	9			
	Fire Legal Liability	\$		each occurrence				
		\$		deductible				
Umbrella Liability	Retroactive Date:	\$		each claim	:	S		
		\$		annual aggregate deductible	c			
	Notice estina Dates	s s		each claim				
Excess Liability	Retroactive Date:	•		***************************************	:	S		
		S		amual aggregate	ė			
		s		deductible				
Endorsement Nos.	600 (ED 01/17), 604 (ED 01/17)							
	Total Deposit	Premium	\$	6,000.00				
		Count	ersigned by	San	Pa	lag		

Authorized Representative

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1365



Phone: 785-296-0127 Fax: 785-559-4250 www.kdheks.gov/bhfr

Laura Kelly, Governor

Lee A. Norman, M.D., Secretary

April 17, 2019

Julie Burkhart, Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, KS 67218

Re: The Medical Care Facilities - Annual Renewal Report Forms

Dear Julie Burkhart,

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter.

As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

In accordance with KSA 65-4922. Medical care facilities; risk management program required; submission of plan; inspections and investigations; approval of plan; reports and records confidential; KAR 28-52-1. General requirements, the Risk Management Plan (RMP) is also which requires all medical care facilities licensed by the Kansas Department of Health and Environment submitted for review to the KDHE Risk Manager no later than 60 days prior to the renewal of the medical care facility licensure. The preferred timeframe is 90 days, as the RMP must be approved prior to the renewal of the medical care facility licensure. We understand your RM Plan may be in the review process with the risk management program and if this applies, please provide proof of RMP submission to the state agency; example... a snap shot showing the date on the electronic submission or the fax cover sheet.

Please return to Health Facilities Program the completed annual report, Hospital/CAH/ASC database worksheet, insurance declaration page along with all appropriate documentation for review.

Please retain the copies of these items for your facility files and mail the original documents to the address below or lois.wilkins@ks.gov. If you have any questions, please contact Lois Wilkins at (785) 296-1258.

Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson Street, Suite 330 Topeka, KS 66612-1365

Marilyn St Peter, RN, Director Health Facilities Program Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson St. Ste. 330 Topeka, KS 66612

Enclosures

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1365



Phone: 785-296-0127 Fox: 785-559-4250 www.kdheks.gov/bhfr

Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

July 1, 2020

South Wind Women's Center 5107 East Kellogg Drive Wichita, Kansas 67218

Re: Medical Care Facility License Approval for July 2020 Ambulatory Surgery Center Facility State I.D. Number: S-078-025

Dear Julie Burkhart,

The Kansas Department of Health and Environment/ Health Facilities Program received the annual report for South Wind Women's Center. The state agency has amended or records according to the ASC licensure application for July 2020. The ASC new effective dates are July 1, 2020 through July 1, 2021. Please maintain a copy of this letter for individuals who may request the effective dates of this ASC license.

As a medical care facility, you will continue to be required to complete an annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with Health Facilities Program during the annual renewal process and if our office can be of any assistance to you, do not hesitate to contact us.

Thank you,

Marílyn St Peter

Marilyn St Peter, RN, Director Health Facilities Program Kansas Department of Health and Environment Bureau of Community Health Systems 1000 SW Jackson St. Ste. 330 Topeka, KS 66612 Marilyn.St.Peter@ks.gov



Select One:	
□ Initial	
Annual Renewal	
☐ Change of Owner	
☐ Amended	

Kansas Department of Health and Environment

Bureau of Community Health Systems & Health Facilities Program

Medical Care Facility Licensure Application
Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:
A. Classification of License select one: General Hospital Critical Access Hospital Special Hospital Ambulatory Surgery Center
B. Name of Medical Care Facility: South Wind Women's Center
Address: 5107 EKellogg Drive City: W. Chita
Zip Code: 67-218 Public Phone: 3162606734 Fax: 3164253451
Web Address: Wichita C. TRUST Numen. agg toustwomen. DRG
* Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:
Days Open: MONDAY - FROMY Operation Hours: OB: ODam - 5: OGDIM
Administration Information:
C. Chief Executive Officer: Juli & A Burkhart
Desk phone 316425 3215 Email address Jour Knowt Qitrust Winen. Deg
* Chief of Medical Staff: Juliet W Marsh
Email address: Julies March @ hush. wm Phone: 316 260 6934
* Director or Risk Manager Name: Chastie Burkhart
Email address: Churchart Ortraus Num Phone! 316 425 3215
Do Not Write Below This Line, State Agency Use Only
Effective Date 07-01-05 Facility I.D. Number 406 400
Renewal Date 07-01-20 Reviewed By Dianut 1.24.20

Ownership Information:

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

- 1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in this entity.
- 2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- 3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.
- 4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
- 5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

II. CONTROL AND GOVERNING AUTHORITY:

A. Disclosing Entity's Name:	TEUS No	men tourbati	
Physical Address: 510-	E Kellog	9 Drue Wichi City/State	taks 67218 Zip code
B. Type of Entity: Corpo	ration for profit	Corporation non-pro	fit
Limited Liability	Company (LLC)	Professional Associa	tes (P.A.)
Government/County_		_ Cther (Explain)	
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address

	General Informa	ution:		
A.	(FOR HOSPITAL	LS ONLY) Number of Beds:	General beds _	Observation beds
	Swing beds	IPPS beds	LTC	Bassinets
В.	Number of Active	e Medical Staff	-	
C.	Check the box	that applies:		
	☐ This appli☐ This appli ☐ This appli accrediting or	ganization.		articipate in Medicare by an approved
D.	Specify the Accre organization full s	diting Organization survey with the decision lette	er.	and provide the current accrediting
	Provide the accred	ditation effective dates		
	*Submit copy of t	the (MCF) Certificate of Pro	fessional Liabili	ty Insurance i.e., the Declaration Letter.
Е.	Check the boxes b	ulations include standards for pelow that are provided by yn ne ASC updated information	our facility. * Pl	ized services, departments, or units. ease submit the completed hospital
	☐ Obste ☑ Outpa ☐ Pedia ☐ Long	ry department trical department trical department tric department Term Care Unit sive coronary care units	☐ Psyd ☐ Dia ☐ Phy ☐ Occ	al Services chiatric Services lysis Services sical Therapy cupational Therapy alation/respiratory Therapy
F	Does this facility yes, please	hold a valid Clinical Labora submit copy a of the current	ntory Improvement CLIA Certifica	ent Act (CLIA) certificate te of Registration.
indivi inforn	dual, or partnership in nation is true and cor	n whom is vested the responsib rect.	oility for operation	rning body, corporation, organization, of the facility and certifies that the above
J	rstand that this applicat LiE A BWW rint Name	ion may be subject to release purs hard Founder &CEC Title		gue ()
3	6 425 3 hone number	215	Date	3 June 2020
The un	dersigned hereby applies ons under the Kansas Lav	to the Kansas Department of Health æ v.	and Environment for a	license to operate this medical care facility is subject to
Returi	n completed application	Healtl 1000 SW	rtment of Health an Community Health h Facilities Progra / Jackson St., Suite eka, Kansas 66612	Systems m
DI	one Number (785) 296		o lois, wilkins@ks.g	Fax Number (785) 559-4250

HOSPITAL PROFESSIONAL LIABILITY PROGRAM

Declarations-Claims Made

Item I. NAMED INSURED and	Address (No. & Street, City, County State	Zin Code)	Policy No	ımber: K	SP0024050		
F	, , ,	, zap codey	7	Renews:	08/15/2020		
South Wind Women's Center LLC 5107 E Kellogg Dr Wichitn, KS 67218		4		General (Ac Pediatric Hos Psychiatric I	The Named Insured is: General (Acute Care) Hospital Pediatric Hospital Psychiatric Hospital Teaching and/or Research		
L				Agent Name USI Midwes 222 S Rivers	& Address:		
Item 2. Policy Period From 08/15/2019 to 08/15/2020 12:01 A.M. standard time at the address of the Name			amed Insured as state	Chicago, IL 60606 and Insured as stated herein.			
	rded is only with respect to su nit of the Company's liability aga						
COVERAGE PARTS	COVERAGES	LIMITS OF	LIABILITY	,	ADVANCE PREMIUI	MS	
Hospital Professional Liability Insurance	Retroactive Date: 08/15/2014	\$	200,000 each clair		\$ 00.000,0		
		S	600,000 annual ag	igregate			
		\$	deductibl	c			
	(I) Bodily Injury or Property Damage Liability	S	each occi	irrence			

Commercial General \$ Liability Insurance (II) Personal Injury/Advertis-ing Injury Coverage 5 annual aggregate Fire Legal Liability \$ each accurrence deductible \$ \$ Umbrella Liability Retronctive Date: each claim \$ \$ annual aggregate \$ deductible S Excess Linbility Retroactive Date: each claim s annual aggregate s

600 (ED 01/17), 604 (ED 01/17) Endersement Nos. 6,000.00 Total Deposit Premium \$

\$

Countersigned by

deductible

Authorized Representative



American Proficiency

PROFICIENCY TESTING SERVICE 2020 CERTIFICATE OF PARTICIPATION

This certifies

S. Wind Women's Center

as a participant in a continuous program of quality assurance for laboratory testing.



Lasad LASON

Daniel C. Edson, President

Lois Wilkins [KDHE]

From:

Lois Wilkins [KDHE]

Sent:

Friday, July 10, 2020 11:39 AM

To:

Christie Burkhart

Cc: Subject: Lois Wilkins [KDHE]
RE: ASC renewal application South Wind Women's Center

Attachments:

ASC Work Sheet 2020.pdf

Hello Christi,

I did not see the database worksheet with the renewal application or CLIA Certificate if the ASC hold one. Will you provide the confirmation of the Risk Management Submission to the RM Mailbox? After receipt I will send the ASC 2020 Approval Letter to you.

Thanks

Lois Wilkins
Certification Coordinator
KDHE
Health Facilities Program
1000 SW Jackson Street, Suite 330
Topeka, Kansas 66612
(785) 296-1258

From: Christie Burkhart <cburkhart@itrustwomen.org>

Sent: Thursday, June 4, 2020 10:04 AM

To: Lois Wilkins [KDHE] <Lois.Wilkins@ks.gov>

Subject: ASC renewal application

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Good morning,

Please find the attached annual renewal application for South Wind Women's Center.

Thank you Christie

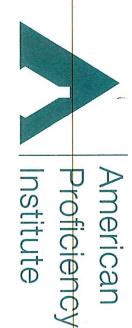
Thank you,

Christie Burkhart Chief Compliance Officer Trust Women O: 316-425-3215 M: 316-641-0709 F: 316-425-3451

cburkhart@itrustwomen.org
www.trustwomen.org



NOTICE: This E-mail (including attachments) is covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, is confidential and may be legally privileged. If you are not the intended recipient, you are hereby notified that any retention, dissemination, distribution or copying of this communication is strictly prohibited. Please reply to the sender that you have received the message in error, then delete it.



PROFICIENCY TESTING SERVICE 2020

CERTIFICATE OF PARTICIPATION This certifies

S. Wind Women's Center



as a participant in a continuous program of quality assurance for laboratory testing.



Daniel C. Edson, President

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current

source, place a '2' on the appropriate line. If the service is not provided, leave blank. Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside

(i.e., not subspecialties). More than one service may be selected. Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories

Name of Facility	CMS Certification Number State ID Number County
South Wind Warreniscenter	12-1412-11
	Street Address; City and Zip code: Telephone No. (Include Area Code)
Identifying Information	SIOT E Kellogg Dr Wich in 67218 316 260 6934
Type of Control	
Select one	2. Non-Profit
Ancillary Services Select 1 or 2	1. Laboratory X 2. Radiology 3. Pharmaceutical Services
Surgical Specialties	1. Dental 2. Endoscopy 3. Ear/Nose/Throat 4. Ob/GynX 5. Ophthalmologic
orion appropriate orional	6. Orthopedic 7. Pain 8. Plastic/Reconstructive 9. Podiatry 10. Other (Specify)
Facility Characteristics	Number of Operating Rooms/Procedures Rooms 2 Date Center Began Providing Service $4/3/23$
Pint Name of Authorized Official	Title Founder & CEO Date Wy Deals
Signature	

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdhe.ks.gov/facilities_licensing

Janet Stanek, Secretary June 26, 2024

Laura Kelly, Governor

Jessica Wannemacher, Acting Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, Kansas 67218-1625

Re: Medical Care Facility License Approval for July 2024 Ambulatory Surgery Center State I.D. Number: S-087-025

Dear Ms. Wannemacher,

The Bureau of Facilities and Licensing received the medical care facility annual renewal application from South Wind Women's Center, LLC. Our records have been amended to reflect the successful license renewal application for July 2024.

The ambulatory surgery center's new effective dates are July 1, 2024, through July 1, 2025.

Please maintain a copy of this letter for individuals who may request the effective dates of this ASC license renewal.

As a medical care facility, you will continue to be required to complete the annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with the Bureau of Facilities and Licensing during the annual renewal process. If our office can be of any further assistance, do not hesitate to contact us.

Thank You,

Jerry Smith, LSCSW

Bureau Director

Lois Wilkins, Program Manager Licensure & Certification Lois.wilkins@ks.gov



July 2024
Select One) Initial
☑ Annual Renewal
☐ Change of Owner ☐ Amended
Amended

Kansas Department of Health and Environment Bureau of Facilities and Licensing

Medical Care Facility Licensure Application
Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:
A. Classification of License select one: Ambulatory Surgery Center General Hospital Critical Access Hospital Special Hospital
B. Name of Medical Care Facility: South Wind Women's Center LLC (d/b/a Trust Women Wichita)
Address: 5107 E. Kellogg Drive City: Wichita
Address: 5107 E. Kellogg Drive City: Wichita Zip Code: 67218 Public Phone: 316-260-6934 Fax: 316-425-3451
Web Address: trustwomen.org
*Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:
Days Open: M-F, occasional Sat/Sun Operation Hours: 8am - 5pm
Administration Information: select title C. Chief Executive Officer or Administrator: Jessica Wannemacher Title: Acting Administrator Desk phone 316-260-6934 Email address jwannemacher@itrustwomen.org * Chief of Medical Staff: Abbey Hardy-Fairbanks MD Email address: hecate987@yahoo.com Phone: 402-239-9586
* Director or Risk Manager Name: Jessica Wannemacher
Email address: jwannemacher@itrustwomen.org Phone: 316-260-6934
Do Not Write Below This Line, State Agency Use Only
Effective Date 7/25/2014 Facility I.D. Number 5087025 Renewal Date 7/1/2024 Reviewed By

Ownership Information:

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

- 1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in this entity.
- 2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- 3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.
- 4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
- 5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

CONTROL AND GOVERNING AUTHORITY: South Wind Women's Center LLC A. Disclosing Entity's Name: 67218 Wichita, KS Physical Address: 5107 E. Kellogg Drive City/State Zip code Corporation for profit Corporation non-profit Limited Liability Company (LLC) Professional Associates (P.A.) Government/County Other (Explain) Jessica Wannemacher Acting Administrate N/A Same Print Name Title Ownership % Address 100% Trust Women Foundation Inc. Same Owner Print Name Title Ownership % Address Sapphire Garcia-Lies President N/A Same Print Name Title Ownership % Address Susan Edgerley N/A Secretary Same Ownership % Print Name Title Address Bruce Price N/A Director Same Print Name Title Ownership % Address Director Keyla Harrison N/A Same Print Name Title Ownership % Address

	General Inform	ation:		
Α.	(FOR HOSPITA	LS ONLY) Number of E	Beds: General b	peds Observation beds
	Swing beds	IPPS beds	_ LTC _	Bassinets
В.	Number of Active	Medical Staff 7		
C.	Check the box the	ut applies:		
	This appli This appli	cant is licensed only cant is licensed, accredicant is licensed, accrediaccrediting organization	ted and deemed	d to participate in Medicare by an
D.	organization full s	diting Organization $\frac{N}{N}$ urvey with the decision	letter.	and provide the current accrediting
	Provide the accred	litation effective dates _	N/A	
	*Submit copy of t	he (MCF) Certificate of	Professional Li	iability Insurance i.e., the Declaration Letter.
Е.	Check the boxes b		by your facility.	organized services, departments, or units. * Please submit the completed hospital
	Obstet Outpat Pediat Long	y department rical department cient department ric department Ferm Care Unit ive coronary care units ogy		Social Services Psychiatric Services Dialysis Services Physical Therapy Occupational Therapy Inhalation/respiratory Therapy
F.		nold a valid Clinical Lab submit copy a of the cur		vement Act (CLIA) certificate ificate of Registration.
individ	s) JW I the uual, or partnership in ation is true and corre	whom is vested the respo	to represent the g	governing body, corporation, organization, ration of the facility and certifies that the above
	7		= 1	unsas Open Records Act (K.S.A. 45-215 et seq.).
	sica Wannemacl			Jessica Wannemacher nettures087470
	Name	Title		nature ³⁰⁸⁷⁴⁷⁰
	260-6934 e number		Date	·
	ersigned hereby applies to ions under the Kansas La			for a license to operate this medical care facility is subject supporting documentation to: kdhe.bfla@ks.gov
		Bureau of 1000 SV Tope	il: kdhe.bfla@ks.gc f Facilities and Lice V Jackson St., Suite eka,Kansas 66612	rensing e 330
-		Phone N	Number (785) 296-0	·0127





KDHE Bureau of Facilities and Licensing 1000 SW Jackson Street, Suite 330 Topeka, KS 66612-1365 Via email: kdhe.bfla@ks.gov

June 21, 2024

RE: South Wind Women's Center (S087025) Change of Administrator

Effective June 13, 2024, I am the Acting Administrator of South Wind Women's Center d/b/a Trust Women Wichita (S087025). I can be reached at jwannemacher@itrustwomen.org or 1-316-260-6934.

Thank you.

Jessica Wannemacher

Jessica Wannemacher

STATE OF KANSAS OFFICE OF SECRETARY OF STATE

CERTIFICATE OF GOOD STANDING

I, SCOTT SCHWAB, Kansas Secretary of State, certify that the records of this office reveal the following:

Business ID: 6710966

Business Name: SOUTH WIND WOMEN'S CENTER LLC

Type: Domestic Limited Liability Company

Jurisdiction: Kansas

was filed in this office on November 19, 2012, and is in good standing, having fully complied with all requirements of this office.

No information is available from this office regarding the financial condition, business activity or practices of this entity.



In testimony whereof: I affix my official certification seal. Done at the City of Topeka, on this day June 18, 2024.

SCOTT SCHWAB
KANSAS SECRETARY OF STATE

Certification Number: 923751-20240618 To verify the validity of this certificate please visit https://www.sos.ks.gov/eforms/BusinessEntity/CertifiedValidationSearch.aspx and enter certificate number.

SWWC Facility License Renewal Attachment C

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS SOUTH WIND WOMENS CENTER DBA TRUST WOMEN, 5107 EAST KELLOGG DRIVE WICHITA, KS 67218

LABORATORY DIRECTOR

CHRISTINA M BOURNE M.D.

CLIA ID NUMBER 17D2056639

EFFECTIVE DATE

11/12/2022

EXPIRATION DATE

11/11/2024

to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address thown benongland other approved locations) may accept human specimens for the purposes of performing laboratory comminations or procedures.

This certificate shall be valid until the expiration dure above, but is subject to revocations supposition, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder. Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revis



DEPARTAR

Clinical Laboratory Improvement & Quality Quality & Safety Oversight Group Center for Clinical Standards and Quality

Certs2_101822

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE) **EFFECTIVE DATE**

BACTERIOLOGY (110) 07/29/2020 MYCOLOGY (120) 09/03/2020 PARASITOLOGY (130) 09/03/2020 ABO & RH GROUP (510) 11/12/2014



LAB CERTIFICATION (CODE)

EFFECTIVE DATE



SWWC Facility License Renewal Attachment D

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER. PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current date.

Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside source, place a '2' on the appropriate line. If the service is not provided, leave blank.

Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one service may be selected.

Name of Facility South Wind Women's Center (d/b/a	Trust Women Wichita)	CMS Certification Number	State ID Number S- 087025	County Site Sedgwick			
	Street Address; City and Z	ip code:		Telephone No. (Include Area Code)			
Identifying Information							
Type of Control Select one	1. Proprietary						
Ancillary Services Select 1 or 2 1. Laboratory 1 2. Radiology 3. Pharmaceutical Services							
Surgical Specialties Select appropriate selections	oat 4. Ob/Gyn						
Facility Characteristics	Number of Operating Roo	oms/Procedures Rooms 2	s/Procedures Rooms 2 Date Center Began Providing Service 4/3/				
Pint Name of Authorized Official Jessi	Acting A	Acting Administrator 6/20/2024					
Signature							
E66368BD3D87470							

Bureau of Faciliies and Licensing 12/2023

Item 1. NAMED INSURED and Address (No. & Street, City, County State, Zip Code)

KAMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

ON BEHALF OF THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN TOPEKA, KANSAS

HEALTHCARE FACILITY PROFESSIONAL LIABILITY PROGRAM Declarations

Policy Number:

KSP0024050

South Wind Women's C	enter II C			\neg	Renews:	08/15/2024	
5107 E Kellogg Dr Wichita, KS 67218	enter ble			(The Named Ac General (Ac Pediatric Hos	ute Care) Hospital 🗆	
				F T	Psychiatric I Teaching and	Hospital □ Hor Research □	
L					Other (Speci	fy):	
Item 2. Policy Period From 12:01 A.M.	standard time at the address of the Na			herein. U	Agent Name JSI Midwes 222 S Rivers Chicago, IL	t ide Plaza 60606	
Item 3. The Insurance afficharge or charges. The lihaving reference thereto.	orded is only with respect to such mit of the Company's liability again	of the follo	wing Cov 1 Coverag	erage Parts a e shall be as	and Coverage stated here	ges as are indicated to all the	y specific premium terms of this policy
COVERAGE PARTS	COVERAGES	LIMITS (OF LIAB	ILITY *	A	DVANCE PREMIU	JMS
Professional Liability Insurance	Retroactive Date: 08/15/2014		500,000	each claim	\$	6,610.00	2 -
		\$ 1, \$,500,000	annual aggre deductible	egate		
\$600,000 annual aggregate. the incident giving rise to a	t, as of the date of the incident giving The Limits of Liability for insureds a claim. (I) Bodily Injury or	not subject to	K.S.A. 40	each occurre	shall be red	uced to the Limits of L	iability in effect on the date o
Commercial General	(I) Bodily Injury or Property Damage Liability	\$		each occurre	ence \$		
Liability Insurance	(II) Personal Injury/Advertis- ing Injury Coverage	\$		annual aggre	egate		
	Fire Legal Liability	\$		each occurre	ence		
_		\$		deductible			1
Umbrella Liability	Retroactive Date:	\$		each claim	\$		
		\$		annual aggre deductible	egate		
		\$		deductible			
Excess Liability	Retroactive Date:	\$		each claim	\$		
		\$		annual aggre	egate		
		\$		deductible			
Endorsement Nos.	600 (ED 01/22), 604 (ED 01/22	2)					
	Total Depos	it Premium	\$	6,610.00			
				8	P		

SWWC Facility License Renewal Attachment A

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

AMENDATORY ENDORSEMENT

THIS POLICY IS ISSUED BY THE COMPANY IN ACCORDANCE WITH AN AGREEMENT BETWEEN THE COMPANY AND THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN UNDER THE SUPERVISION OF THE COMMISSIONER OF INSURANCE OF THE STATE OF KANSAS, PURSUANT TO KSA 40-3401 et seq.

COVERAGE AMENDMENTS FOR PROFESSIONAL SERVICES OUTSIDE THE STATE

It is hereby understood and agreed that the coverage and/or applicable prior acts coverage under Coverages A and B as defined by the policy is limited as follows for those non-resident health care providers and for those Kansas resident health care providers who have resided outside the state of Kansas and who, during such time, complied with the Health Care Stabilization Fund on a non-resident basis:

During any period(s) in which the above described health care providers resided outside the state of Kansas, the coverage and/or applicable prior acts coverage under Coverages A and B provided by the policy apply only to those Professional Services rendered, or which should have been rendered, within the state of Kansas provided that claim is made and suit is brought against the Insured within the United States of America, its territories of possessions.

COVERAGE C

It is hereby understood and agreed that the provisions of Coverage C shall not apply to this policy issued by the Kansas Health Care Provider Insurance Availability Plan, and no excess coverage is provided under this policy.

DIVIDENDS

It is hereby understood and agreed that the provisions relating to dividends contained in this policy shall not apply.

MUTUAL POLICY CONDITION - MEMBERSHIP

It is hereby understood that the provisions relating to membership contained in this policy shall not apply.

MUTUAL POLICY CONDITION - VOTING

It is hereby understood and agreed that the provisions relating to the voting rights of members shall not apply.

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form

(for policy periods effective on and after Jan. 1, 2022)

Kansas law requires to Care Stabilization Fu policy. A copy of this	ctive d	ate of the			FOR HCSF U	SE O	NLY				
SECTION I – Healt	h Care Provider Identific	ation and Resi	dency								
Health Care Provid		d Women's C									anaras atras
Last name, first name, middle initial, and professional acronym, or full name of medical care facility or other type of health care providence.										provide	
Health Care Provider's Legal Kansas Residence: 5107 E Kellogg Dr, Wichita KS 672											
Street Address and City (For a hospital or other facility, or a business entity, this should be the legal location.) Zip Daytime Phone (316) 260,6934 Health Care Provider's									.) Zip C	ode	
Number:	(316) 260-6934			mail A	1000						
Mailing Address: (Optional, if not the same as legal residence) Street Address or P.O. Box, City, State, Zip Code											
	e same as legal residence)	Street	Address or P.C). Box,	City, State	, Zip Coc	ie				
SECTION II - HCSF	\$500,000/\$1,500,0	00			,			·			
rendering profes agency and requ	n Care Provider: If you sional services as a Ko est that your license b	ansas resident e made inacti	your profess thealth care ive.	sional e prov	ider, you	ı should	immedio	ately contac	t yo	ur licer	
SECTION III - Health	h Care Stabilization Fund S	Surcharge and Ins	urance Policy	Inform	ation	The second secon	Fund s 1 to 14	the state of the same of the same	or Fuses 15	ind to 24	
HCSF Rate Provider's Fund Basic Cove Classification License Compliance Premiu Number Year Amour				n	HCSF Class Group Number	Sur Payme	HCSF Surcharge Agment From Rate Tables HCSF HCSF % Based Surcharge Surcharge Percent Payment			ed ge	
	S087025	1	\$ 6,610.	00	15	\$		20 %	\$	1,322	2.00
9	The published HCSF surch	arge for Fund cla	sses 1 to 15 wa	as modi	fied for th	e followin	ng reason o	r reasons:			9
The policy	y is issued for only part of a	year and the sur	charge was pro Th	orated b	oased on the	e number ded to the	of days di nearest wh	vided by 365. role percent) w	as		%.
The policy "extraordi	y is a unique part-time polic nary circumstances").	y issued by the p	orimary profess	sional li	iability ins	urer (requ	iires explai The part-tir	nation belowur ne factor used	ıder was		%.
This Kans	as resident health care prov The applicable Missour	ider has an active i modification fa	e Missouri lice ctor was includ	nse. ded in tl	he surchar	ge calcula	ition and th	e factor used v	vas		%.
Type of Primary Co	verage Professional Liabili	ty Insurance Poli	су:	Occurr	ence		Claims Ma	de			
Insurance Company Name:											
Name of Agent or C				Polic	y Number	: K	SP00240)50			
Agent or Company Rep. Email Address: SPATRY@KAMMCO.COM				Coverage Effective Date: 08/15/2023					\neg		
Agent or CompanyRep. Phone Number: (785) 232-2224				1	erage Expir		0045				
For insurer ex	xplanation of extraordi	nary circumst	ances:			FOR	RHCSFU	JSE ONLY			

KAMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN CERTIFICATE OF INSURANCE

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not affirmatively or negatively amend, extend or alter the coverage afforded by the policy below. This Certificate of Insurance does not constitute a contract between issuing insurer(s), authorized representative or producer, and the Certificate Holder.

Important: If the Certificate Holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. 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).

POLICY NUMBER: KSP0024050

FOR THE PERIOD FROM <u>08/15/2023</u> 12:01 a.m. TO <u>08/15/2024</u> 12:01 a.m. standard time at the address of the Insured as stated herein.

NAME AND ADDRESS OF CERTIFICATE HOLDER:

NAME AND ADDRESS OF HEALTH CARE PROVIDERS:

South Wind Women's Center LLC 5107 E Kellogg Dr Wichita, KS 67218

This is to certify that the coverages listed below have been issued to the Health Care Provider named above for the policy period indicated above. The insurance afforded by the policy described herein is subject to all terms, exclusions, and conditions of such policy. Notwithstanding the Limits of Liability stated below, the Limits of Liability shall be reduced to the minimum professional liability insurance ("Basic Coverage") required by K.S.A. 40-3402, as of the date of the incident giving rise to a claim which may result in the Limits of Liability being reduced to \$200,000 per claim and \$600,000 annual aggregate. The Limits of Liability for insureds not subject to K.S.A. 40-3401 et seq. shall be reduced to the Limits of Liability in effect on the date of the incident giving rise to a claim. The Limits of Liability below for the Health Care Stabilization Fund (HCSF) are based upon the limits option selected by the health care provider as shown in the company's records as of the date of issuance of this Certificate of Insurance and are subject to the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 et seq.

LIMITS OF LIABILITY

 Hospital Professional Liability
 KAMMCO
 HCSF OPTION
 TOTAL

 Each Claim
 500,000
 500,000
 1,000,000

 Annual Aggregate
 1,500,000
 1,500,000
 3,000,000

116-1H (ED 01/2022)

(Page 1 of 2)

San Patry

AUTHORIZED REPRESENTATIVE

07/11/2023

DATE OF ISSUE

116-1H (ED 01/2022)

(Page 2 of 2)





Shukeyla Harrison Trust Women Attention: KDHE, Lois Wilkins

05/17/2025

Dear Lois Wilkins,

Thank you for your request and my apologies for the delay in communication regarding Trust Women's formal change with administrative leadership and who is now the administrator of facility.

On April 10th, 2024, Trust Women underwent an executive leadership change. The past Co-Executives, Rebecca Tong and Schaunta Boyd-James are no longer employed through any avenue with Trust Women. I have stepped into the role of Interim Chief Executive Officer for a minimum of 12 months. I will update your organization prior to April 11, 2025, if my tenure will be extended.

If you have any questions, please feel free to reach out by email at Kharrison@itrustwomen.org or by phone at 785-473-3436.

Regards,

Shukeyla Harrison, Ph.D. Interim CEO 785-473-3436 Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdhe.ks.gov/facilities_licensing

Janet Stanek, Secretary

Laura Kelly, Governor

Dear Provider,

Re: The Medical Care Facilities - Annual Renewal Report Forms

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information Forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter. Please check to assure all elements for the renewal applications are submitted.

As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

Attachment In accordance with KSA 65-4922 and KAR 28-52-1, an annual Risk Management Plan (RMP) submission is required for all medical care facilities licensed by the Kansas Department of Health and Environment. The RMP needs to be submitted to KDHE 60-90 days prior to the renewal of the medical care facility licensure. The preferred method of submission is via email to kdhe.riskmanagement@ks.gov. The RMP must be complete and approved by KDHE prior to the renewal of the medical care facility licensure.

Attachment If the medical care facility is registered with the Kansas Business Center, please submit the Certificate of Good Standing, you can obtain the certificate at the BESS Website at https://www.kansas.gov/bess/flow/main?execution=e4s1.

Return all applicable documentation, the renewal application, Hospital/CAH or ASC database worksheet, insurance declaration page along with any supporting documentation to the Bureau of Facilities and Licensing to complete the medical care facility annual review process.

Email Annual Renewal Report Forms to:

kdhe.bfla@ks.gov

KDHE Bureau of Facilities and Licensing 1000 SW Jackson Street, Suite 330 Topeka, KS 66612-1365 Office phone: (785) 296-0127

Jerry Smith, LSCSW Bureau Director KDHE Bureau of Facilities and Licensing

Enclosures



Licensure Renewal

Facility State Id: S087025

Federal CMS Certification Nbr:

Facility Region:

Facility Name: SOUTH WIND WOMEN'S CENTER, LLC

Facility Rank:

Type:

L Class: ASC

C Class:

5107 EAST KELLOGG DRIVE Facility Address:

Facility City: **WICHITA**

> **SEDGWICK** County:

Facility State: KS

Facility Zipcode: 67218

Facility Address:

Facility City:

Facility State:

Facility Zipcode:

Phone: 316-425-3215

Admin Name: REBECCA TONG, CO-CEO

Total Number of Beds:

Effective Date: 07/25/2014

Renewal Date: 04/01/2024

Renewal Letter Sent:

Renewal Application Received:

Renewal Approved:

Notes:

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeko, KS 66612-1365



Phone: 785-296-0127 Fox: 785-559-4250 www.kdheks.gov/bhfr

Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

June 24, 2021

South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, Kansas 67218

Re: Medical Care Facility License Approval for July 2021 Ambulatory Surgery Center State I.D. Number: S-087-025

Dear Julie Burkhart,

The Health Facilities Program, Acute & Continuing Care received the medical care facility annual report for South Wind Women's Center, LLC. The state agency has amended or records according to the license renewal application received for July 2021. The ambulatory surgery center's new effective dates are July 1, 2021 through July 1, 2022. Please maintain a copy of this letter for individuals who may request the effective dates of this ASC license.

As a medical care facility, you will continue to be required to complete an annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with Health Facilities Program during the annual renewal process and if our office can be of any assistance to you, do not hesitate to contact us.

Thank you,

Marílyn St Peter

Marilyn St Peter, Director
Health Care Facilities Program
Acute & Continuing Care
Bureau of Community Health Systems
Kansas Department of Health and Environment
1000 SW Jackson St. Ste. 330
Topeka, KS 66612
Marilyn.St.Peter@ks.gov

_ suly 25, 21



Select One:	
☐ Initial	
Annual Renewal	
☐ Change of Owner	
☐ Amended	_

Kansas Department of Health and Environment

Bureau of Community Health Systems & Health Facilities Program

Medical Care Facility Licensure Application Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility	dentification:	
A. Classification of License	Special Hospita	Critical Access Hospital Ambulatory Surgery Center
Address: 5107 Zip Code: 67218 Web Address: www. * Ambulatory Surgery Cen	Public Phone: 316266 U. + Rustwomen. ORG ters List Days and Hours of Operat	City: Wichita 134 Fax: 316 425 3451
Administration Inform		
	: Julie A Burkha	nt
Desk phone 316 47	5 3215 Email address	burkhart @ itrust Numen. Drg
F ' /	Juliet Wmargh	
Email address: Jules	Marsh (Mush Com Phone	316 260 6934
×/ タタと * Director or Risk Manag	ger Name: Christie Bu	rkhart
Email address: Chul	ektople itrustwomen. who	316425 3215
1		ency Use Only
Effective Date 7.25	Facility I.	D. Number <u>.5087035</u>
Renewal Date	O ユ L Reviewed	Ву



Board of Directors

Alison Regan, President Anthony Tenbrink, Treasurer Jessica Wells-Hasan, Secretary Susan Edgerley Bruce Price, M.D. Jennifer Stastny

July 29, 2021

Kansas Department of Health and Environment Bureau of Community Health Systems Health Care Facilities Program, Acute & Continuing Care 1000 SW Jackson Street, Suite 330 Topeka, Kansas 66612

To whom it may concern:

Trust Women that owns and operates South Wind Women's Center (DBA Trust Women Wichita) has new administrators. Detailed below are the administrators that have been removed with effective dates.

- Julie Burkhart, effective 7/9/2021 is no longer the CEO
- Christie Burkhart, effective 7/9/2021 is no longer Risk Manager

Detailed below are the new administrators with effective dates.

- Schaunta James-Boyd, effective 7/6/2021 is the Co-Chief Executive Officer
 o sjamesboyd@itrustwomen.org
- Rebecca Tong, effective 7/12/2021 is the Co-Chief Executive Officer
 - o rtong@itrustwomen.org
- Ashley Brink, effective 7/19/2021 is the Director
 - o abrink@itrustwomen.org

Please let us know if you require any additional information or documentation. Thank you all for the important work you do.

Sincerely,

Alison Regan, President

Susan Edgerley

Anthony Tenbrink, Treasurer

Bruce Price, M.D.

Jessica Wells-Hasan, Secretary

Jennifer Stastny

Ownership Information:

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

- 1. List the name(s) and addresses of each person who has any direct or indirect ownership of 5 percent or more in this entity.
- 2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- 3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.
- 4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
- 5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

II. CONTROL AND GOVERNING AUTHORITY:

A. Disclosing Entity's Name:	TRUST N	Jomen Louns	Aton	
Physical Address: _5\0	I E Kello	gg Drive Wiche City/State	ta, KS 67 Zip code	218
B. Type of Entity: Corporat	tion for profit	Corporation non-pro	fit	
Limited Liability Co	ompany (LLC)	Professional Associa	ites (P.A.)	
Government/County		_ Other (Explain)		
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	

	General Information:							
A	(FOR HOSPITALS ONLY) Number of Beds	s: General bed	S Observation beds					
	Swing beds IPPS beds	LTC	Bassinets					
F	. Number of Active Medical Staff							
(C. Check the box that applies:							
	This applicant is licensed only This applicant is licensed, accredited This applicant is licensed, accredited accrediting organization.	and deemed to						
J	O. Specify the Accrediting Organization organization full survey with the decision let	ter.	and provide the current accrediting					
	Provide the accreditation effective dates							
	*Submit copy of the (MCF) Certificate of Pro-	ofessional Liab	ility Insurance i.e., the Declaration Letter.					
)	The licensing regulations include standards f Check the boxes below that are provided by database and or the ASC updated information	your facility. *	anized services, departments, or units. Please submit the completed hospital					
	☐ Surgery department ☐ Obstetrical department ☐ Outpatient department ☐ Pediatric department ☐ Long Term Care Unit ☐ Intensive coronary care units ☐ Radiology		ocial Services sychiatric Services ialysis Services hysical Therapy occupational Therapy halation/respiratory Therapy					
	F. Does this facility hold a valid Clinical Labor west, please submit copy a of the currer	ratory Improve nt CLIA Certifi	ment Act (CLIA) certificate cate of Registration.					
indi info	ials) The undersigned is authorized to vidual, or partnership in whom is vested the responsionation is true and correct.	ibility for operat	ion of the facility and certifies that the above					
I und	erstand that this application may be subject to release pur	11 11	as Open Records Act (K. 8.A. 45-215 et seq.).					
_	Print Name Title Signature 316 425 3215 Phone number Date							
The	andersigned hereby applies to the Kansas Department of Health sions under the Kansas Law. Return completed applies	and Environment folication & docum	or a license to operate this medical care facility is subject to centation to:					
	: KDHE / Health Facilities Program Acute & Continuing Care 1000 SW Jackson St., Suite 330 Topeka, Kansas 66612 Phone Number (785) 296-0127 Fax Number (785) 559-4250							
II	I HOHE I WHILE (100) ETO OTE!							



2021 Trust Women Board of Directors and Staff Leadership

Board of Directors

Alison Regan, JD, President Jessica Wells-Hasan, Secretary Anthony Tenbrink, Treasurer Susan Edgerley Bruce Price, MD Jennifer Stastny

Staff Leadership

Schaunta James-Boyd, Co-Executive Director Rebecca Tong, Co-Executive Director Jules Marsh, MD, Chief Medical Officer Khadijah Bland, Director of Development Zach Gingrich-Gaylord, Director of Communications Ashley Brink, Wichita Clinic Director Kailey Voellinger, Oklahoma City Clinic Director

Business Entity Search

Date: 07/23/2021

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by customers with the secretary of State's office to ensure accurate information. When filing a Uniform Commercial Code statement on an entity, consult with your attorney to ensure the correct debtor name.

Business Summary

Current Entity Name

Business Entity ID Number

TRUST WOMEN FOUNDATION INC.

4747515

Current Mailing Address: JULIE BURKHART - 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Business Entity Type: FOREIGN NOT FOR PROFIT

Date of Formation in Kansas: 08/30/2013

State of Organization: DC

Current Status: STATUS PENDING EXAMINATION OF A/R

Resident Agent and Registered Office

Resident Agent: JULIE BURKHART

Registered Office: 5107 EAST KELLOGG DRIVE, WICHITA, KS 67218

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2019

Next Annual Report Due: 06/15/2021

Forfeiture Date: 09/15/2021

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

I.ABORATORY NAME AND ADDRESS SOUTH WIND WOMENS CENTER 5107 EAST KELLOGG DRIVE WICHITA, KS 67218 CLIA ID NUMBER 17D2056639

EFFECTIVE DATE

11/12/2020 EXPIRATION DATE

LABORATORY DIRECTOR

JULIET MARSH M.D.

11/11/2022

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263n) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above muned laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CCIVIS SIGNATURE AS A MIDICAND SHARKES

Amy M. Zale, Acting Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

172 corts2_111020

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their offective date:

LAB CERTIFICATION (CODE)
ABO & RH GROUP (510)

EFFECTIVE DATE 11/12/2014 LAB CERTIFICATION (CODE)

EFFECTIVE DATE

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current date.

Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside source, place a '2' on the appropriate line. If the service is not provided, leave blank.

Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one service may be selected.

Name of Facility	County Site CMS Certification Number State ID Number	
THE STATE OF THE S	1421+	
Street Address; City and Zip code:	Street Address; City and Zip code: Telephone No. (Include Area Code)	(i
Identifying Information	5107 5 KOLLING Drive Wichda 67218 3162606934	7
Type of Control Select one		
Ancillary Services Select 1 or 2	1. Laboratory X 2. Radiology 3. Pharmaceutical Services 2.	
Surgical Specialties	1. Dental 2. Endoscopy 3. Ear/Nose/Throat 4. Ob/Gyn χ 5. Ophthalmologic	
Select appropriate selections	6. Orthopedic 7. Pain 8. Plastic/Reconstructive 9. Podiatry 10. Other (specify)_	
Facility Characteristics	Number of Operating Rooms/Procedures Rooms 2 Date Center Began Providing Service $4/3/20/3$	3/2013
Pint Name of Authorized Official July E A Bull Knowt	aret Title Date ACEO 14 April 2	
signature		

HOSPITAL PROFESSIONAL LIABILITY PROGRAM Declarations-Claims Made

Item 1. NAMED INSURED and	Address (No. & Street,	City, Cou	mty State, Zip Code)	Policy N	lumber:	KSP0024050
South Wind Women's Center	LLC			٦	Renews:	08/15/2021
5107 E Kellogg Dr Wichita, KS 67218					General Pediatric Psychial Teachin Other (S	
L				_1	USI Mid	lame & Address: Iwest iverside Plaza
Item 2. Policy Period From	08/15/2020	to	08/15/2021			, IL 60606
•	12:01 A.M. standa	ard time a	at the address of the N	amed Insurc	d as stated h	erein.
to a mile a constant	1. (-1 1	de of the following t	Courses De	eta and Co	vorage as are indicated

Item 3. The Insurance afforded is only with respect to such of the following Coverage Parts and Coverages as are indicated by specific premium charge or charges. The limit of the Company's liability against each such Coverage shall be as stated herein, subject to all the terms of this policy having reference thereto.

COVERAGE PARTS	COVERAGES	LIMITS	OF LIAB	ILITY	ADVA	NCE PREMIUMS
Hospital Professional Liability Insurance	Retroactive Date: 08/15/2014	\$	200,000	each claim	\$	6,000.00
,		\$	600,000	annual aggregate		
		\$		deductible		
	(I) Bodily Injury or Property Damage Liability	\$		each occurrence		
Commercial General Liability Insurance					\$	
•	(II) Personal Injury/Advertis- ing Injury Coverage	\$		annual aggregate		
	Fire Legal Liability	\$		each occurrence		
		\$		deductible		
Umbrella Liability	Retroactive Date:	\$		each claim	\$	
		\$		annual aggregate		
		\$		deductible		
Excess Liability	Retroactive Date:	\$		each claim	\$	
		\$		annual aggregate		
		\$		deductible		
Endorsement Nos.	600 (ED 01/17), 604 (ED 01/17	7)			·	
	Total Depos	it Premium	\$	6,000.00		
				Sam F) mtm.	
		Counte	ersigned by		25	

Authorized Representative

603 (ED 07/2011)

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1365



Phone: 785-296-0127 Fox: 785-559-4250 www.kdheks.gov/bhfr

Lee A. Norman, M.D., Secretary March 29, 2021 Laura Kelly, Governor

Julie Burkhart, Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, KS 67218

Re: The Medical Care Facilities - Annual Renewal Report Forms

Dear Administrator,

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information Forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter.

As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

In accordance with KSA 65-4922. Medical care facilities; risk management program required; submission of plan; inspections and investigations; approval of plan; reports and records confidential; KAR 28-52-1. General requirements, the Risk Management Plan (RMP) is also which requires all medical care facilities licensed by the Kansas Department of Health and Environment submitted for review to the KDHE Risk Management Program no later than 60 days prior to the renewal of the medical care facility licensure. The preferred timeframe is 90 days, as the RMP must be approved prior to the renewal of the medical care facility licensure. We understand your RM Plan may be in the review process with the risk management program and if this applies, please provide proof of RMP submission to the state agency; example... a snap shot showing the date on the electronic submission to RM Plan kdhe.Riskmanagement@ks.gov.

If applicable to this hospital this hospital and if the entity is registered with the Kansas Business Center, please submit the Certificate of Good Standing, you can obtain the certificate at the BESS Website at https://www.kansas.gov/bess/flow/main?execution=e4s1.

Return all applicable documentation the renewal application, Hospital/CAH or ASC database worksheet, insurance declaration page along with any supporting documentation to Health Facilities Program to complete the medical care facility annual review process.

Email to: lois.wilkins@ks.gov or mail to KDHE / Health Facilities Program, Acute & Continuing Care 1000 SW Jackson Street, Suite 330

Topeka, KS 66612-1365

Office phone: (785) 296-0127

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdheks.gov/bhfr

Janet Stanek, Secretary

Laura Kelly, Governor

June 14, 2022

South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, Kansas 67218-1625

Re: Medical Care Facility License Approval for July 2022 Ambulatory Surgery Center State I.D. Number: S-087-025

Dear Rebecca Tong

The Health Facilities Program, Acute & Continuing Care received the medical care facility annual report for South Wind Women's Center, LLC. The state agency has amended or records according to the license renewal application received for July 2022. The hospital's new effective dates are July 1, 2022 through July 1, 2023.

Please maintain a copy of this letter for individuals who may request the effective dates of this hospital license.

As a medical care facility, you will continue to be required to complete an annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with Health Facilities Program during the annual renewal process and if our office can be of any assistance to you, do not hesitate to contact us.

Thank you,

Marilyn St Peter
Marilyn St Peter, Director
Health Care Facilities Program
Acute & Continuing Care
Bureau of Community Health Systems



Select One:

Initial

APR 26 2022

APR 26 2022

The Grand Transfer of Health and Transfer o

Select One:	
☐ Initial	
∠ Annual Renewal	
☐ Change of Owner	
☐ Amended	

Kansas Department of Health and Environment

Bureau of Community Health Systems & Health Facilities Program

Medical Care Facility Licensure Application Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:
A. Classification of License select one: General Hospital Special Hospital Ambulatory Surgery Center
B. Name of Medical Care Facility: South Wind Women's Center
Address: 5107 E Kellogg Or. City: Wichita
Address: 5107 E (Cellogg Or. City: Wichita Zip Code: 67218-1625 Public Phone: 316-260-6934 Fax: 316-444-0409
Web Address:
* Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:
Days Open: Operation Hours: _ 8 AM - 5 PM
Administration Information:
C. Chief Executive Officer: Rebecca Tong
Desk phone 316-425-3215 Email address rtong @itrust women.org
* Chief of Medical Staff: Christian Bourne, MO
Email address: Cbourne @ itrustwomen.org Phone: 316-260-6934
* Director or Risk Manager Name: Ashley Bank
Email address: abrink gitaust women. org Phone: 316-260-6934
Do Not Write Below This Line, State Agency Use Only
Effective Date 7.25.2014 Facility I.D. Number 5087-025
Renewal Date 7.25.2022 Reviewed By 57 1.11.23

Ownership Information:

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

- 1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in this entity.
- 2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- 3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.
- 4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
- 5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

II. CONTROL AND GOVERNING AUTHORITY:

A. Disclosing Entity's Name:	_Trust Won	nen Foundation		
A. Disclosing Entity's Name: Physical Address: 5107	E Kellogg	Or. Wichita/ City/State	< S	<u>67218-</u> [67 Zip code
B. Type of Entity: Corpo	oration for profit	Corporation non-pro	ofit	
Limited Liability	Company (LLC)	Professional Associa	ates (P.A.)	
Government/County_		Other (Explain)		<u> </u>
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	
Print Name	Title	Ownership %	Address	

	General Inform	ation:		
A.	(FOR HOSPITAL	LS ONLY) Number of Bed	ls: General beds	Observation beds
	Swing beds	IPPS beds	_ LTC	Bassinets
В.	Number of Activ	e Medical Staff		
C.	Check the box	that applies:		
	This appli			participate in Medicare by an approved
D.	Specify the Accre organization full s	diting Organization survey with the decision le	tter.	and provide the current accrediting
	Provide the accred	litation effective dates		
	*Submit copy of t	he (MCF) Certificate of Pr	rofessional Liabi	lity Insurance i.e., the Declaration Letter.
E.	Check the boxes b	ulations include standards a below that are provided by the ASC updated information	your facility. * F	nized services, departments, or units. Please submit the completed hospital
	☐ Obste ☐ Outpa ☐ Pediat ☐ Long	ry department trical department tient department cric department Term Care Unit ive coronary care units logy	Psy Dia Ph	cial Services rehiatric Services religional Therapy cupational Therapy nalation/respiratory Therapy
F.	Does this facility, please	hold a valid Clinical Labor submit copy a of the curre	ratory Improvem nt CLIA Certifica	ent Act (CLIA) certificate ate of Registration.
	s) <u> </u>	whom is vested the respons	represent the gove ibility for operatio	erning body, corporation, organization, n of the facility and certifies that the above
				Open Records Act (K.S.A. 45-215 et seq.).
Reb	ecca Tong Cont Name	Title	R. B. Signati	eca low
316 Ph	-425-3215 one number		Date	11/2027
	ersigned hereby applies t ns under the Kansas Law		and Environment for lication & documen	a license to operate this medical care facility is subject to atation to:
		Acute of 1000 S	lealth Facilities Prog & Continuing Care W Jackson St., Suite oeka, Kansas 66612	2330
	Phone Number (78	35) 296-0127		Fax Number (785) 559-4250

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS SOUTH WIND WOMENS CENTER 5107 EAST KELLOGG DRIVE WICHITA, KS 67218 17D2056639

EFFECTIVE DATE

11/12/2020

EXPIRATION DATE

LABORATORY DIRECTOR

JULIET MARSH M.D.

11/11/2022

Pursuant to Section 353 of the Public Fleath Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

(CMS

Amy M. Zale, Acting Director Division of Laboratory Services Survey and Certification Group Center for Clinical Standards and Quality

172 cens2_111020

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their offective date:

LAB CERTIFICATION (CODE)

ABO & RH GROUP (510)

EFFECTIVE DATE

LAB CERTIFICATION (CODE)

EFFECTIVE DATE

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER. PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Business Entity Search

Date: 04/29/2022

Be advised the business information on this page is for summary informational purposes only. It is not an official filing with the Secretary of State's office and should not be relied on as such. Please view actual documents filed by custome with the secretary of State's office to ensure accurate information. When filing a Uniform Commercial Code statement c an entity, consult with your attorney to ensure the correct debtor name.

Business Summary

Current Entity Name

Business Entity ID Number

SOUTH WIND WOMEN'S CENTER LLC

6710966

Current Mailing Address: Rebecca Tong - 5107 E. Kellogg Dr., Wichita, KS 67218

Business Entity Type: KANSAS LTD LIABILITY COMPANY

Date of Formation in Kansas: 11/19/2012

State of Organization: KS

Current Status: CORPORATION IS DELINQUENT

Resident Agent and Registered Office

Resident Agent: Rebecca Tong

Registered Office: 5107 E Kellogg, WICHITA, KS 67218

Annual Reports

The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2020

Next Annual Report Due: 04/15/2022

Forfeiture Date: 07/15/2022

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current

Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside source, place a '2' on the appropriate line. If the service is not provided, leave blank.

Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one service may be selected.

Name of Facility South Wind Wemen's Center	CMS Certification Number State ID Number State State ID Number State ID Number State ID Number Seda 2017	1 6
Identifying Information	ddress; City and Zip code: 7 E. Kellogg Dr. Nichita, KS 67218 3	
Type of Control Select one	1. Proprietary	
Ancillary Services Select 1 or 2	1. Laboratory 2. Radiology 3. Pharmaceutical Services 3.	
Surgical Specialties Select appropriate selections	1. Dental 2. Endoscopy 3. Ear/Nose/Throat 4. Ob/Gyn X 5. Ophthalmologic 6. Orthopedic 7. Pain 8. Plastic/Reconstructive 9. Podiatry 10. Other (Specify)	
Facility Characteristics	Number of Operating Rooms/Procedures Rooms 2 Date Center Began Providing Service $\frac{4/3}{2^{\delta_0}}$	S
Pint Name of Authorized Official Rebecca Tong	Title Co-Executive Director 4/11/22	
Signature Rham		*

HOSPITAL PROFESSIONAL LIABILITY PROGRAM Declarations-Claims Made

Item 1. NAMED INSURED and A		ty, Co	ınty State, Zip	Code)	Policy Nu	mber:	KSP0024050	,
South Wind Women's Center I	LLC					Kellews.	08/15/2022	2
5107 E Kellogg Dr						TL M	17 11	
Wichita, KS 67218							ed Insured is:	
						Pediatric	Acute Care) Ho Hospital □	ospital L
						Psychiatri	ic Hospital 🗆	
						Teaching	and/or Researc	h□
						Other (Sp.	ecify):	
II.						Agent Na	me & Address:	
L						USI Midw	vest	
Itam 2 Dalian Basis J.F.	00450004					222 S Riv	erside Plaza	
Item 2. Policy Period From	08/15/2021	to	08/15/2022			Chicago, I		
	12:01 A.M. standard	time a	t the address	s of the Name	d Insured a	s stated her	ein.	
Item 3. The Insurance afforded in charge or charges. The limit of having reference thereto.	is only with respect t the Company's liabili	o suc ty aga	h of the folianst each si	llowing Cove uch Coverage	rage Parts shall be a	and Cove as stated h	rages as are in erein, subject	ndicated to all the

by specific premium e terms of this policy

COVERAGE PARTS	COVERAGES	LIMIT	ΓS OF LIAE	BILITY	ADV	ANCE PREMIUMS
Hospital Professional Liability Insurance	Retroactive Date: 08/15/2014	\$	200,000	each claim	\$	6,000.00
	•	\$	600,000	annual aggregate	•	0,000.00
		\$		deductible		
Commercial General	(I) Bodily Injury or Property Damage Liability	\$		each occurrence		
Liability Insurance ·					\$	
	(II) Personal Injury/Advertis- ing Injury Coverage	\$		annual aggregate		
	Fire Legal Liability	\$		each occurrence		
		\$		deductible		
Umbrella Liability	Retroactive Date:	\$		each claim		
					\$	
		\$		annual aggregate		
		\$		deductible		
Excess Liability	Retroactive Date:	\$		each claim		
					\$	
		\$		annual aggregate		
		\$		deductible		
Endorsement Nos.	600 (ED 01/17), 604 (ED 01/17)					
	Total Deposit	Premium	\$	6,000.00		

			88-8
	\$	(deductible
Endorsement Nos.	600 (ED 01/17), 604 (ED 01/17)		
	Total Deposit Premium \$	6	5,000.00
	Countersigned I	> oy	San Patry
			Authorized Representative

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdheks.gov/bhfr

Janet Stanek, Acting Secretary

Laura Kelly, Governor

March 30, 2022

Schaunta James-Boyd, Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, KS 67218

Re: The Medical Care Facilities - Annual Renewal Report Forms

Dear Administrator,

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information Forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter. Please check to assure all elements for the renewal applications are submitted.

As a medical care facility licensee, you need to remain in compliance with the Health Care
Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities
licensed by the Kansas Department of Health and Environment to maintain professional liability
insurance. Please provide this office the name of the insurance company providing professional liability
coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number
and the effective dates of the coverage.
In accordance with KSA 65-4922 and KAR 28-52-1, an annual Risk Management Plan (RMP)
submission is required for all medical care facilities licensed by the Kansas Department of Health and
Environment. The RMP needs to be submitted to KDHE 60-90 days prior to the renewal of the medical
care facility licensure. The preferred method of submission is via email to kdhe.riskmanagement@ks.gov.
The RMP must be complete and approved by KDHE prior to the renewal of the medical care facility
licensure.
If the medical care facility is registered with the Kansas Business Center, please submit the
Certificate of Good Standing, you can obtain the certificate at the BESS Website at
https://www.kansas.gov/bess/flow/main?execution=e4s1.

Return all applicable documentation, the renewal application, Hospital/CAH or ASC database worksheet, insurance declaration page along with any supporting documentation to Health Facilities Program to complete the medical care facility annual review process.

Email Annual Renewal Report Forms to: lois.wilkins@ks.gov or mail to KDHE / Health Facilities Program, Acute & Continuing Care 1000 SW Jackson Street, Suite 330

Topeka, KS 66612-1365

Office phone: (785) 296-0127

Marilyn St Peter, RN, Director Health Facilities Program Acute & Continuing Care 1000 SW Jackson St. Ste. 330 Topeka, KS 66612

Enclosures

KDHE/HFP, Acute & Continuing Care revision 2022

A.

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdhe.ks.gov/facilities_licensing

Janet Stanek, Secretary

Laura Kelly, Governor

June 28, 2023

Rebecca Tong, CEO South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, Kansas 67218-1625

Re: Medical Care Facility License Approval for July 2023 Ambulatory Surgery Center State I.D. Number: S-087-025

Dear Ms. Tong

The Kansas Department of Health and Environment, Bureau of Facilities and Licensing received the medical care facility annual renewal application from South Wind Women's Center, LLC. Our records have been amended to reflect the successful license renewal application for July 2023.

The ambulatory surgery center's new effective dates are July 1, 2023 through July 1, 2024.

Please maintain a copy of this letter for individuals who may request the effective dates of this ASC license renewal.

As a medical care facility, you will continue to be required to complete the annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with the Bureau of Facilities and Licensing during the annual renewal process. If our office can be of any further assistance, do not hesitate to contact us.

Thank You,

Jerry Smith, LSCSW Bureau Director

Bureau of Facilities and Licensing

Kansas Department of Health and Environment

1000 SW Jackson Street, Suite 330

Topeka, Kansas 66612

C: Lois Wilkins, Licensure & Certification Coordinator Lois.wilkins@ks.gov

Health Facilities Program



MAY 0 4 2023

Acute & Continuing Care

0.	
Select One:	
☐ Initial Annual Renewal	
☐ Change of Owner	

July 25,

☐ Amended

Kansas Department of Health and Environment

Bureau of Community Health Systems & Health Facilities Program

Medical Care Facility Licensure Application Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:
A. Classification of License select one: General Hospital Special Hospital Ambulatory Surgery Center
B. Name of Medical Care Facility: South Wind Women's Center, LLC
Address: 5107 E. Kellogg City: Wichita
Address: 5107 E. Kellogg City: Wichita Zip Code: 67218 Public Phone: 316-260-6934 Fax: 316-425-3451
Web Address: www.trustwomen.org
* Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:
Days Open: M-F Operation Hours: 8am-5pm
Administration Information:
C. Chief Executive Officer or Administrator: Rebecca Tong Title: Co-Executive Director
Desk phone 316-260-6934 Email address rtong@itrustwomen.org
* Chief of Medical Staff: Christina M. Bourne, MD
Email address: cbourne@itrustwomen.org Ashlov Brink
* Director or Risk Manager Name: Ashley Brink
Email address: abrink@itrustwomen.org Phone: 316-260-6934
Do Not Write Below This Line, State Agency Use Only
Effective Date 7, 25. 2014 Facility I.D. Number 8087.025,
Renewal Date 7. 25.2023 Reviewed By M Cronister 5/16/23

Ownership Information:

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

- 1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in this entity.
- 2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- 3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.
- 4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
- 5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

II. CONTROL AND GOVERNING AUTHORITY:

A. Disclosing Entity's Name:	rust Wome	n Foundation	, Inc.
Physical Address: 5107 E. K	ellogg		
B. Type of Entity: Corporati		City/State Corporation non-pr	Zip code
Limited Liability Con	mpany (LLC)	Professional Associ	ates (P.A.)
Government/County		Other (Explain)	
Rebecca Tong	Co-Executive D	Director 0	5107 E. Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Schaunta James-Boyd	Co-Executive D	Director 0	5107 E. Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Alison Regan	Board President	0	5107 E Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Anthony Tenbrink	Treasuer	0	5107 E Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Jessica Hasan-Wells	Secretary	0	5107 E Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
KDHE/HFP Acute & Continuing Care Rev	. 2020: 3/2022		4 0 6 5

	General Informa	tion:			
A.	(FOR HOSPITAL	S ONLY) Numb	er of Beds:	General bed	ds Observation beds
	Swing beds	IPPS bed	s	LTC	Bassinets
В.	Number of Active	Medical Staff	13		
C.	— This applic	cant is licensed of cant is licensed, a	accredited	nd deemed t	to participate in Medicare by an approved
D.	Specify the Accred organization full so				and provide the current accredi
	Provide the accred	itation effective	dates	21 TO 10	
	*Submit copy of the	ne (MCF) Certif	cate of Prof	essional Lia	bility Insurance i.e., the Declaration Lette
E.		elow that are pro	vided by yo	our facility.	ganized services, departments, or units. * Please submit the completed hospital
	Obsteti Outpat Pediati Long T	y department rical department ient department ic department Ferm Care Unit ve coronary care		□ P □ E □ F	Social Services Psychiatric Services Dialysis Services Physical Therapy Occupational Therapy Inhalation/respiratory Therapy
F.					ement Act (CLIA) certificate icate of Registration.
	s) RT I the uual, or partnership in ation is true and corre	whom is vested th	norized to rep ne responsibi	present the go lity for operat	overning body, corporation, organization, tion of the facility and certifies that the above
			-		sas Open Records Act (K.S.A. 45-215 et seq.).
Rel	pecca Jong nt Name	<u>Co-Executive</u> Title	Dir.	Signa	Oblea Try
31 Pho	6-425-32 one number	15		Date	4/20/2023
	ersigned hereby applies to as under the Kansas Law.			l Environment fo	or a license to operate this medical care facility is subject that the subject is the subject to the subject is subject to the subject to the subject is subject to the s
		:	Acute & 0 1000 SW .	th Facilities Pro Continuing Card Jackson St., Su Ja, Kansas 6661	e ite 330
	Phone Number (785) 206-0127	торека	a, 18a115a5 0001	Fax Number (785) 550-4250

Limited Liability Company Annual Report

1. LLC Name: SOUTH WIND WOMEN'S CENTER LLC

2. Business Entity ID No.: 67109663. Tax Closing Date: December 2022

4. State of Organization: KS5. Official Mailing Address:

Rebecca Tong, 5107 E. Kellogg Dr., Wichita KS 67218



Electronic File Stamp Information:

Filed

- Date:04/11/2023
- Time: 11:25:07 AM

6. Members who own 5% or more of capital (Kansas LLCs only):

Trust Women Foundation, Inc. - 5107 E. Kellogg Dr. Wichita, KS 67218

"I declare under penalty of perjury pursuant to the laws of the state of Kansas that the foregoing is true and correct."

Executed on April 11, 2023

Signature of Authorized Person: Rebecca Tong



2023 Trust Women Board of Directors and Staff Leadership

Board of Directors

Alison Regan, Esq., President, City of West Hollywood, Staff Attorney- 2019
Susan Edgerley, Kansas State University, Professor- 2019
Bruce Price, MD, McLean Hospital, Chief, Department of Neurology- 2014
Jennifer Stastny, Ascension Senior Living, Executive Director- 2020
Jessica Wells-Hasan, Secretary, Center for NYC Neighborhoods, Vice President for Development & External Affairs- 2019
Anthony Tenbrink, Tenbrink Enterprises, President
Schaunta James-Boyd- Trust Women Foundation, Inc.-Co-Executive Director
Rebecca Tong-Trust Women Foundation, Inc. - Co-Executive Director

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS SOUTH WIND WOMENS CENTER DBA TRUST WOMEN 5107 EAST KELLOGG DRIVE WICHITA, KS 67218

17D2056639

CLIA ID NUMBER

EFFECTIVE DATE

11/12/2022

EXPIRATION DATE

11/11/2024

LABORATORY DIRECTOR

CHRISTINA M BOURNE M.D.

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Monique Spruill

Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
Onality & Safery Oversight Group

Quality & Safety Oversight Group Center for Clinical Standards and Quality

216 Certs2_101822

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE) EFFECTIVE DATE

BACTERIOLOGY (110) 07/29/2020 MYCOLOGY (120) 09/03/2020 PARASITOLOGY (130) 09/03/2020 ABO & RH GROUP (510) 11/12/2014



LAB CERTIFICATION (CODE)

EFFECTIVE DATE



FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current date.

Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside source, place a '2' on the appropriate line. If the service is not provided, leave blank.

Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one service may be selected.

				County Site
Name of Facility South Wind Women's Center, LLC		CMS Certification Number 17- D2056639	State ID Number S- 087025	Sedgwick County
	Street Address; City and Zip code:	ode:		Telephone No. (Include Area Code)
Identifying Information	5107 E. Kellogg Dr. Wich	Wichita, KS 67218	-	316-260-6934
Type of Control Select one	1. Proprietary 2. Non-Profit 3. Government			
Ancillary Services Select 1 or 2	1. Laboratory	2. Radiology	3. Pharmaceutical Services	al Services
Surgical Specialties	1. Dental	by 3. Ear/Nose/Throat	oat 4. Ob/Gyn	V 5. Ophthalmologic
Select appropriate selections	6. Orthopedic 7. Pain_	in8. Plastic/Reconstructive_	structive9. Podiatry _	iry 10. Other (specify)
Facility Characteristics	Number of Operating Rooms/Procedures Rooms	Procedures Rooms 2	Date Cent	04/11/2013 Date Center Began Providing Service
Pint Name of Authorized Official Rebecca Tong	ecca Tong	Title Co-Executive Director	irector	Date 05/08/2023
Signature Repeter for		Email Address rtong@	Email Address rtong@itrustwomen.org	
	0			

KAMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

ON BEHALF OF THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN TOPEKA, KANSAS

HEALTHCARE FACILITY PROFESSIONAL LIABILITY PROGRAM Declarations

Item 1. NAMED INSURED and Address (No. & Street, City, County State, Zip Code)

603 (ED 01/22)

Policy Number:

Renews:

KSP0024050

08/15/2023

South Wind Women's Cer	nter LLC								
5107 E Kellogg Dr Wichita, KS 67218				P P	ediatric H Sychiatric	Acute Ca Iospital Hospit	are) Hospital □ □		
II					ther (Spe	cify):			
tem 2. Policy Period From	08/15/2022 to 0	8/15/2023			gent Nan	ne & Ad	ldress:		
	tandard time at the address of the Na		ed as stated		JSI Midw				
herein.					22 S Rive				
					Chicago, Il			.~	
Item 3. The Insurance affo charge or charges. The lin having reference thereto.	rded is only with respect to such nit of the Company's liability again	of the fol st each su	lowing Cov sch Coverag	erage Parts a se shall be as	stated he	rages as erein, su	s are indicated by ubject to all the t	erms of this po	licy
COVERAGE PARTS	COVERAGES	LIMITS	OF LIAB	ILITY *		ADVA	NCE PREMIU	MS	
Professional Liability Insurance	Retroactive Date: 08/15/2014	\$	500,000	each claim		\$	6,000.00		
		\$	1,500,000	annual aggre	egate				
		\$		deductible					
Coverage") required by K.S. \$200,000 per claim and \$600	of Liability stated above, the Limits A. 40-3402, as of the date of the incio,000 annual aggregate. The Limits on the date of the incident giving rise	dent giving f Liability to a claim	g rise to a cla for insureds	aim which mag not subject to	y result in K.S.A. 4	the Lin	nits of Liability be	eing reduced to	
	(I) Bodily Injury or Property Damage Liability	\$		each occurre	ence				
Commercial General	Property Damage Endomey					\$			
Liability Insurance						4			
	(II) Personal Injury/Advertis- ing Injury Coverage	\$		annual aggre	egate				
	Fire Legal Liability	\$		each occurre	ence				
		\$		deductible					
Umbrella Liability	Retroactive Date:	\$		each claim		\$			
		\$		annual aggr	egate				
		\$		deductible					
Excess Liability	Retroactive Date:	\$		each claim		\$			
		\$		annual aggr	egate				
		\$		deductible					
Endorsement Nos.	600 (ED 01/22), 604 (ED 01/22	2)	e						
	Total Deposi	it Premium	n \$	6,000.00					
		Count	ersigned by	San	Pa	try			
		Count		Au	thorized !	Represe	entative		

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

AMENDATORY ENDORSEMENT

THIS POLICY IS ISSUED BY THE COMPANY IN ACCORDANCE WITH AN AGREEMENT BETWEEN THE COMPANY AND THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN UNDER THE SUPERVISION OF THE COMMISSIONER OF INSURANCE OF THE STATE OF KANSAS, PURSUANT TO KSA 40-3401 et seq.

COVERAGE AMENDMENTS FOR PROFESSIONAL SERVICES OUTSIDE THE STATE

It is hereby understood and agreed that the coverage and/or applicable prior acts coverage under Coverages A and B as defined by the policy is limited as follows for those non-resident health care providers and for those Kansas resident health care providers who have resided outside the state of Kansas and who, during such time, complied with the Health Care Stabilization Fund on a non-resident basis:

During any period(s) in which the above described health care providers resided outside the state of Kansas, the coverage and/or applicable prior acts coverage under Coverages A and B provided by the policy apply only to those Professional Services rendered, or which should have been rendered, within the state of Kansas provided that claim is made and suit is brought against the Insured within the United States of America, its territories of possessions.

COVERAGE C

It is hereby understood and agreed that the provisions of Coverage C shall not apply to this policy issued by the Kansas Health Care Provider Insurance Availability Plan, and no excess coverage is provided under this policy.

DIVIDENDS

It is hereby understood and agreed that the provisions relating to dividends contained in this policy shall not apply.

MUTUAL POLICY CONDITION - MEMBERSHIP

It is hereby understood that the provisions relating to membership contained in this policy shall not apply.

MUTUAL POLICY CONDITION - VOTING

It is hereby understood and agreed that the provisions relating to the voting rights of members shall not apply.

KAMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN CERTIFICATE OF INSURANCE

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not affirmatively or negatively amend, extend or alter the coverage afforded by the policy below. This Certificate of Insurance does not constitute a contract between issuing insurer(s), authorized representative or producer, and the Certificate Holder.

Important: If the Certificate Holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. 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).

POLICY NUMBER: KSP0024050

FOR THE PERIOD FROM <u>08/15/2022</u> 12:01 a.m. TO <u>08/15/2023</u> 12:01 a.m. standard time at the address of the Insured as stated herein.

NAME AND ADDRESS OF CERTIFICATE HOLDER:

NAME AND ADDRESS OF HEALTH CARE PROVIDERS:

South Wind Women's Center LLC 5107 E Kellogg Dr Wichita, KS 67218

This is to certify that the coverages listed below have been issued to the Health Care Provider named above for the policy period indicated above. The insurance afforded by the policy described herein is subject to all terms, exclusions, and conditions of such policy. Notwithstanding the Limits of Liability stated below, the Limits of Liability shall be reduced to the minimum professional liability insurance ("Basic Coverage") required by K.S.A. 40-3402, as of the date of the incident giving rise to a claim which may result in the Limits of Liability being reduced to \$200,000 per claim and \$600,000 annual aggregate. The Limits of Liability for insureds not subject to K.S.A. 40-3401 et seq. shall be reduced to the Limits of Liability in effect on the date of the incident giving rise to a claim. The Limits of Liability below for the Health Care Stabilization Fund (HCSF) are based upon the limits option selected by the health care provider as shown in the company's records as of the date of issuance of this Certificate of Insurance and are subject to the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 et seq.

LIMITS OF LIABILITY

Hospital Professional Liability	KAMMCO	HCSF OPTION	TOTAL
Each Claim	500,000	500,000	1,000,000
Annual Aggregate	1,500,000	1,500,000	3,000,000

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form (for policy periods effective on and after Jan. 1, 2022)

Care Stabilization Fu	the insurance company to und Board of Governors completed form must als	within thirty de	avs of the eff	ective	date of th	Health e basic	FOR HOSE U	JSE O	NLY	
	h Care Provider Identifi								7	
Health Care Provid	er's Name South Win	nd Women's	Center LLC	;						
Last	name, first name, middle i	nitial, and profes	sional acronyn	n, or fi	all name of	medical care facility	or other type	of hea	Ith care	provid
Health Care Provide	r's		-				4.3	7		-
Legal Kansas Reside			tal or other fac	rility (ar a busine	ss entity, this should b	KS	notion.	672	18
Daytime Phone Number:	(316) 260-6934		Health (Care Pr	rovider's [Address:	o wany, and another	e nie regai rot	canon.	Дрс	oue
Mailing Address: (Optional, if not the	same as legal residence)	Street	Address or P.O	D. Box	. City, Stat	e, Zip Code				
SECTION II - HCSF	Coverage Limit				, -1.2, -1.1.					
	\$500,000/\$1,500,0	00								
rendering profes. agency and requi	Care Provider: If you sional services as a Ko est that your license b	ansas resident e made inacti	your profes: thealth card ve.	siona e pro	vider, yo	insurance policy u should immedia	because yo tely contac	u are	no lo Ir licer	nger osing
SECTION III - Health	Care Stabilization Fund S	urcharge and Ins	urance Policy	Inforn	nation	For Fund Classes 1 to 14	The state of the s	or Fu ses 15	Section 1997 and 1997	
HCSF Rate Classification Number	Provider's License Number	Fund Compliance Year	Premiun	ic Coverage Premium Amount HCSF Class Surcharge Surcharge Payment From Number Rate Tables HCSF Surcharge Percent				\$	HCSF % Based Surcharge Payment	
S087025 1 \$ 6,000.00 15 \$ 20 %							\$	1,20	0.00	
The policy	he published HCSF surcha	rge for Fund clas	ses 1 to 15 wa	s mod	ified for th	e following reason or	reasons:			
	is issued for only part of a		Th	e prora	ation (roun	ded to the nearest who	de percent) w	as		%.
extraordin	is a unique part-time polic ary circumstances").				liability ins	urer (requires explana The part-tim	ition belowun e factor used	der was		%.
	s resident health care provi The applicable Missouri	modification fac	tor was includ	nse. led in t	he surchar	ge calculation and the	factor used w	as		%.
Type of Primary Cov	erage Professional Liabilit	y Insurance Polic	ry:	Оссип		Claims Mad				
Insurance Company Name:						X				
Name of Agent or Ot Company Representa	tive: Sara Patry			Polic	y Number:	KSP00240	50			
Agent or Company R Email Add		ММСО.СОМ		Cove	erage Effec	tive Date: 08/15/2	2022			\neg
Agent or CompanyR Phone Numb	ep. per: (785) 232-2224				rage Expir	001451	2023			\neg
For insurer ex	planation of extraordin	nary circumsta	nces:			FOR HCSF U	SE ONLY			

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdhe.ks.gov/facilities_licensing

Laura Kelly, Governor

3/

Janet Stanek, Secretary

April 10, 2023

Schaunta James-Boyd, Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, KS 67218

Re: The Medical Care Facilities - Annual Renewal Report Forms

Dear Mr. James-Boyd,

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information Forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter. Please check to assure all elements for the renewal applications are submitted.

As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

In accordance with KSA 65-4922 and KAR 28-52-1, an annual Risk Management Plan (RMP) submission is required for all medical care facilities licensed by the Kansas Department of Health and Environment. The RMP needs to be submitted to KDHE 60-90 days prior to the renewal of the medical care facility licensure. The preferred method of submission is via email to kdhe.riskmanagement@ks.gov. The RMP must be complete and approved by KDHE prior to the renewal of the medical care facility licensure.

If the medical care facility is registered with the Kansas Business Center, please submit the Certificate of Good Standing, you can obtain the certificate at the BESS Website at https://www.kansas.gov/bess/flow/main?execution=e4s1.

Return all applicable documentation, the renewal application, Hospital/CAH or ASC database worksheet, insurance declaration page along with any supporting documentation to Health Facilities Program to complete the medical care facility annual review process.

Email Annual Renewal Report Forms to:
lois.wilkins@ks.gov and Debi.Thompson@ks.gov
Bureau of Facilities and Licensing
Health Facilities Program
1000 SW Jackson Street, Suite 330
Topeka, KS 66612-1365
Office phone: (785) 296-0127

Jerry Smith, LSCSW Bureau Director Bureau of Facilities and Licensing

Enclosures

A.

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdhe.ks.gov/facilities_licensing

Janet Stanek, Secretary

Laura Kelly, Governor

June 28, 2023

Rebecca Tong, CEO South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, Kansas 67218-1625

Re: Medical Care Facility License Approval for July 2023 Ambulatory Surgery Center State I.D. Number: S-087-025

Dear Ms. Tong

The Kansas Department of Health and Environment, Bureau of Facilities and Licensing received the medical care facility annual renewal application from South Wind Women's Center, LLC. Our records have been amended to reflect the successful license renewal application for July 2023.

The ambulatory surgery center's new effective dates are July 1, 2023 through July 1, 2024.

Please maintain a copy of this letter for individuals who may request the effective dates of this ASC license renewal.

As a medical care facility, you will continue to be required to complete the annual report each year.

Your license includes a statement that indicates the provisions of KSA 65-425 through 65-441 applies, unless sooner revoked or suspended for failure to comply with the requirements of said law. Your license shall remain in effect upon filing the next annual report as prescribed by law.

A new license will be issued upon a change in the name on the face of the license or change in the address.

We appreciate your cooperation with the Bureau of Facilities and Licensing during the annual renewal process. If our office can be of any further assistance, do not hesitate to contact us.

Thank You,

Jerry Smith, LSCSW Bureau Director

Bureau of Facilities and Licensing

Kansas Department of Health and Environment

1000 SW Jackson Street, Suite 330

Topeka, Kansas 66612

C: Lois Wilkins, Licensure & Certification Coordinator Lois.wilkins@ks.gov

Health Facilities Program



MAY 0 4 2023

Acute & Continuing Care

0.	
Select One:	
☐ Initial Annual Renewal	
☐ Change of Owner	

July 25,

☐ Amended

Kansas Department of Health and Environment

Bureau of Community Health Systems & Health Facilities Program

Medical Care Facility Licensure Application Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:
A. Classification of License select one: General Hospital Special Hospital Ambulatory Surgery Center
B. Name of Medical Care Facility: South Wind Women's Center, LLC
Address: 5107 E. Kellogg City: Wichita
Address: 5107 E. Kellogg City: Wichita Zip Code: 67218 Public Phone: 316-260-6934 Fax: 316-425-3451
Web Address: www.trustwomen.org
* Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:
Days Open: M-F Operation Hours: 8am-5pm
Administration Information:
C. Chief Executive Officer or Administrator: Rebecca Tong Title: Co-Executive Director
Desk phone 316-260-6934 Email address rtong@itrustwomen.org
* Chief of Medical Staff: Christina M. Bourne, MD
Email address: cbourne@itrustwomen.org Ashlov Brink
* Director or Risk Manager Name: Ashley Brink
Email address: abrink@itrustwomen.org Phone: 316-260-6934
Do Not Write Below This Line, State Agency Use Only
Effective Date 7, 25. 2014 Facility I.D. Number 8087.025,
Renewal Date 7. 25.2023 Reviewed By M Cronister 5/16/23

Ownership Information:

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

- 1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in this entity.
- 2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- 3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.
- 4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.
- 5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

II. CONTROL AND GOVERNING AUTHORITY:

A. Disclosing Entity's Name:	rust Wome	n Foundation	, Inc.
Physical Address: 5107 E. K	ellogg		
B. Type of Entity: Corporati		City/State Corporation non-pr	Zip code
Limited Liability Con	mpany (LLC)	Professional Associ	ates (P.A.)
Government/County		Other (Explain)	
Rebecca Tong	Co-Executive D	Director 0	5107 E. Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Schaunta James-Boyd	Co-Executive D	Director 0	5107 E. Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Alison Regan	Board President	0	5107 E Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Anthony Tenbrink	Treasuer	0	5107 E Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Jessica Hasan-Wells	Secretary	0	5107 E Kellogg Dr. Wichita, KS 67218
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
KDHE/HFP Acute & Continuing Care Rev	. 2020: 3/2022		4 0 6 5

	General Informa	tion:			
A.	(FOR HOSPITAL	S ONLY) Numb	er of Beds:	General bed	ds Observation beds
	Swing beds	IPPS bed	s	LTC	Bassinets
В.	Number of Active	Medical Staff	13		
C.	— This applic	cant is licensed of cant is licensed, a	accredited	nd deemed t	to participate in Medicare by an approved
D.	Specify the Accred organization full so				and provide the current accredi
	Provide the accred	itation effective	dates	21 TO 10	
	*Submit copy of the	ne (MCF) Certif	cate of Prof	essional Lia	bility Insurance i.e., the Declaration Lette
E.		elow that are pro	vided by yo	our facility.	ganized services, departments, or units. * Please submit the completed hospital
	Obsteti Outpat Pediati Long T	y department rical department ient department ic department Ferm Care Unit ve coronary care		□ P □ E □ F	Social Services Psychiatric Services Dialysis Services Physical Therapy Occupational Therapy Inhalation/respiratory Therapy
F.					ement Act (CLIA) certificate icate of Registration.
	s) RT I the uual, or partnership in ation is true and corre	whom is vested th	norized to rep ne responsibi	present the go lity for operat	overning body, corporation, organization, tion of the facility and certifies that the above
			-		sas Open Records Act (K.S.A. 45-215 et seq.).
Rel	pecca Jong nt Name	<u>Co-Executive</u> Title	Dir.	Signa	Oblea Try
31 Pho	6-425-32 one number	15		Date	4/20/2023
	ersigned hereby applies to as under the Kansas Law.			l Environment fo	or a license to operate this medical care facility is subject that the subject is the subject to the subject is subject to the subject to the subject is subject to the s
		:	Acute & 0 1000 SW .	th Facilities Pro Continuing Card Jackson St., Su Ja, Kansas 6661	e ite 330
	Phone Number (785) 206-0127	торека	a, 18a115a5 0001	Fax Number (785) 550-4250

Limited Liability Company Annual Report

1. LLC Name: SOUTH WIND WOMEN'S CENTER LLC

2. Business Entity ID No.: 67109663. Tax Closing Date: December 2022

4. State of Organization: KS5. Official Mailing Address:

Rebecca Tong, 5107 E. Kellogg Dr., Wichita KS 67218



Electronic File Stamp Information:

Filed

- Date:04/11/2023
- Time: 11:25:07 AM

6. Members who own 5% or more of capital (Kansas LLCs only):

Trust Women Foundation, Inc. - 5107 E. Kellogg Dr. Wichita, KS 67218

"I declare under penalty of perjury pursuant to the laws of the state of Kansas that the foregoing is true and correct."

Executed on April 11, 2023

Signature of Authorized Person: Rebecca Tong



2023 Trust Women Board of Directors and Staff Leadership

Board of Directors

Alison Regan, Esq., President, City of West Hollywood, Staff Attorney- 2019
Susan Edgerley, Kansas State University, Professor- 2019
Bruce Price, MD, McLean Hospital, Chief, Department of Neurology- 2014
Jennifer Stastny, Ascension Senior Living, Executive Director- 2020
Jessica Wells-Hasan, Secretary, Center for NYC Neighborhoods, Vice President for Development & External Affairs- 2019
Anthony Tenbrink, Tenbrink Enterprises, President
Schaunta James-Boyd- Trust Women Foundation, Inc.-Co-Executive Director
Rebecca Tong-Trust Women Foundation, Inc. - Co-Executive Director

CENTERS FOR MEDICARE & MEDICAID SERVICES CLINICAL LABORATORY IMPROVEMENT AMENDMENTS CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS SOUTH WIND WOMENS CENTER DBA TRUST WOMEN 5107 EAST KELLOGG DRIVE WICHITA, KS 67218

17D2056639

CLIA ID NUMBER

EFFECTIVE DATE

11/12/2022

EXPIRATION DATE

11/11/2024

LABORATORY DIRECTOR

CHRISTINA M BOURNE M.D.

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Monique Spruill

Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
Onality & Safery Oversight Group

Quality & Safety Oversight Group Center for Clinical Standards and Quality

216 Certs2_101822

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE) EFFECTIVE DATE

BACTERIOLOGY (110) 07/29/2020 MYCOLOGY (120) 09/03/2020 PARASITOLOGY (130) 09/03/2020 ABO & RH GROUP (510) 11/12/2014



LAB CERTIFICATION (CODE)

EFFECTIVE DATE



FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Ambulatory Surgery Center Updated Information

(Please read the following instructions before completing this form)

The ASC completes and signs this form for updated information upon request of the State agency periodically; please answer all questions as of the current date.

Item III: If a service is provided directly by the facility, place a '1' on the appropriate line. If a service is provided under an arrangement with an outside source, place a '2' on the appropriate line. If the service is not provided, leave blank.

Item IV: Place an 'X' on the appropriate line representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties). More than one service may be selected.

				County Site
Name of Facility South Wind Women's Center, LLC		CMS Certification Number 17- D2056639	State ID Number S- 087025	Sedgwick County
	Street Address; City and Zip code:	ode:		Telephone No. (Include Area Code)
Identifying Information	5107 E. Kellogg Dr. Wich	Wichita, KS 67218	-	316-260-6934
Type of Control Select one	1. Proprietary 2. Non-Profit 3. Government			
Ancillary Services Select 1 or 2	1. Laboratory	2. Radiology	3. Pharmaceutical Services	al Services
Surgical Specialties	1. Dental	by 3. Ear/Nose/Throat	oat 4. Ob/Gyn	V 5. Ophthalmologic
Select appropriate selections	6. Orthopedic 7. Pain_	in8. Plastic/Reconstructive_	structive9. Podiatry _	iry 10. Other (specify)
Facility Characteristics	Number of Operating Rooms/Procedures Rooms	Procedures Rooms 2	Date Cent	04/11/2013 Date Center Began Providing Service
Pint Name of Authorized Official Rebecca Tong	ecca Tong	Title Co-Executive Director	irector	Date 05/08/2023
Signature Repeter for		Email Address rtong@	Email Address rtong@itrustwomen.org	
	0			

KAMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

ON BEHALF OF THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN TOPEKA, KANSAS

HEALTHCARE FACILITY PROFESSIONAL LIABILITY PROGRAM Declarations

Item 1. NAMED INSURED and Address (No. & Street, City, County State, Zip Code)

603 (ED 01/22)

Policy Number:

Renews:

KSP0024050

08/15/2023

South Wind Women's Cer	nter LLC								
5107 E Kellogg Dr Wichita, KS 67218				C P P	ediatric H Sychiatric	Acute Ca Iospital Hospit	are) Hospital □ □		
II					ther (Spe	cify):			
tem 2. Policy Period From	08/15/2022 to 0	8/15/2023			gent Nan	ne & Ad	ldress:		
	tandard time at the address of the Na		ed as stated		JSI Midw				
herein.					22 S Rive				
					Chicago, Il			.~	
Item 3. The Insurance affo charge or charges. The lin having reference thereto.	rded is only with respect to such nit of the Company's liability again	of the fol st each su	lowing Cov sch Coverag	erage Parts a se shall be as	stated he	rages as erein, su	s are indicated by ubject to all the t	erms of this po	licy
COVERAGE PARTS	COVERAGES	LIMITS	OF LIAB	ILITY *		ADVA	NCE PREMIU	MS	
Professional Liability Insurance	Retroactive Date: 08/15/2014	\$	500,000	each claim		\$	6,000.00		
		\$	1,500,000	annual aggre	egate				
		\$		deductible					
Coverage") required by K.S. \$200,000 per claim and \$600	of Liability stated above, the Limits A. 40-3402, as of the date of the incio,000 annual aggregate. The Limits on the date of the incident giving rise	dent giving f Liability to a claim	g rise to a cla for insureds	aim which mag not subject to	y result in K.S.A. 4	the Lin	nits of Liability be	eing reduced to	
	(I) Bodily Injury or Property Damage Liability	\$		each occurre	ence				
Commercial General	Property Damage Endomey					\$			
Liability Insurance						4			
	(II) Personal Injury/Advertis- ing Injury Coverage	\$		annual aggre	egate				
	Fire Legal Liability	\$		each occurre	ence				
		\$		deductible					
Umbrella Liability	Retroactive Date:	\$		each claim		\$			
		\$		annual aggr	egate				
		\$		deductible					
Excess Liability	Retroactive Date:	\$		each claim		\$			
		\$		annual aggr	egate				
		\$		deductible					
Endorsement Nos.	600 (ED 01/22), 604 (ED 01/22	2)	e						
	Total Deposi	it Premium	n \$	6,000.00					
		Count	ersigned by	San	Pa	try			
		Count		Au	thorized !	Represe	entative		

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

AMENDATORY ENDORSEMENT

THIS POLICY IS ISSUED BY THE COMPANY IN ACCORDANCE WITH AN AGREEMENT BETWEEN THE COMPANY AND THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN UNDER THE SUPERVISION OF THE COMMISSIONER OF INSURANCE OF THE STATE OF KANSAS, PURSUANT TO KSA 40-3401 et seq.

COVERAGE AMENDMENTS FOR PROFESSIONAL SERVICES OUTSIDE THE STATE

It is hereby understood and agreed that the coverage and/or applicable prior acts coverage under Coverages A and B as defined by the policy is limited as follows for those non-resident health care providers and for those Kansas resident health care providers who have resided outside the state of Kansas and who, during such time, complied with the Health Care Stabilization Fund on a non-resident basis:

During any period(s) in which the above described health care providers resided outside the state of Kansas, the coverage and/or applicable prior acts coverage under Coverages A and B provided by the policy apply only to those Professional Services rendered, or which should have been rendered, within the state of Kansas provided that claim is made and suit is brought against the Insured within the United States of America, its territories of possessions.

COVERAGE C

It is hereby understood and agreed that the provisions of Coverage C shall not apply to this policy issued by the Kansas Health Care Provider Insurance Availability Plan, and no excess coverage is provided under this policy.

DIVIDENDS

It is hereby understood and agreed that the provisions relating to dividends contained in this policy shall not apply.

MUTUAL POLICY CONDITION - MEMBERSHIP

It is hereby understood that the provisions relating to membership contained in this policy shall not apply.

MUTUAL POLICY CONDITION - VOTING

It is hereby understood and agreed that the provisions relating to the voting rights of members shall not apply.

KAMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN CERTIFICATE OF INSURANCE

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not affirmatively or negatively amend, extend or alter the coverage afforded by the policy below. This Certificate of Insurance does not constitute a contract between issuing insurer(s), authorized representative or producer, and the Certificate Holder.

Important: If the Certificate Holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. 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).

POLICY NUMBER: KSP0024050

FOR THE PERIOD FROM <u>08/15/2022</u> 12:01 a.m. TO <u>08/15/2023</u> 12:01 a.m. standard time at the address of the Insured as stated herein.

NAME AND ADDRESS OF CERTIFICATE HOLDER:

NAME AND ADDRESS OF HEALTH CARE PROVIDERS:

South Wind Women's Center LLC 5107 E Kellogg Dr Wichita, KS 67218

This is to certify that the coverages listed below have been issued to the Health Care Provider named above for the policy period indicated above. The insurance afforded by the policy described herein is subject to all terms, exclusions, and conditions of such policy. Notwithstanding the Limits of Liability stated below, the Limits of Liability shall be reduced to the minimum professional liability insurance ("Basic Coverage") required by K.S.A. 40-3402, as of the date of the incident giving rise to a claim which may result in the Limits of Liability being reduced to \$200,000 per claim and \$600,000 annual aggregate. The Limits of Liability for insureds not subject to K.S.A. 40-3401 et seq. shall be reduced to the Limits of Liability in effect on the date of the incident giving rise to a claim. The Limits of Liability below for the Health Care Stabilization Fund (HCSF) are based upon the limits option selected by the health care provider as shown in the company's records as of the date of issuance of this Certificate of Insurance and are subject to the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 et seq.

LIMITS OF LIABILITY

Hospital Professional Liability	KAMMCO	HCSF OPTION	TOTAL
Each Claim	500,000	500,000	1,000,000
Annual Aggregate	1,500,000	1,500,000	3,000,000

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form (for policy periods effective on and after Jan. 1, 2022)

Kansas law requires the insurance company to forward this completed form to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the effective date of the basic policy. A copy of this completed form must also be given to the health care provider.											
SECTION I - Health Care Provider Identification and Residency											
Health Care Provid	ler's Name: South Win	nd Women's	Center LLC	;							
Last name, first name, middle initial, and professional acronym, or full name of medical care facility or other type of health care provide											
Health Care Provide	r's						4.3	7		-	
Legal Kansas Residence: 5107 E Kellogg Dr, Wichita KS 67218 Street Address and City (For a hospital or other facility, or a business entity, this should be the legal location.) Zip Code											
Daytime Phone Number:	(316) 260-6934	Health Care P			ovider's Address;	ider's					
Mailing Address: (Optional, if not the same as legal residence) Street Address or P.O. Box, City, State, Zip Code											
SECTION II - HCSF Coverage Limit											
-											
Date Signed Health Care Provider's Signature											
Notice to Health Care Provider: If you discontinue your professional liability insurance policy because you are no longer											
rendering professional services as a Kansas resident health care provider, you should immediately contact your licensing agency and request that your license be made inactive.											
agency and requi	est that your license b	e made inacti	ve.								
SECTION III Health Core Stabilization Ford State											
SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information					For Fund Classes 1 to 14	For Fund Classes 15 to 24					
				HCSF	HCSF				100		
HCSF Rate	Provider's	Fund	Basic Coverage		Class	Surcharge	HCSF 9 Surcharge St		HCSF % Based Surcharge		
Classification Number	License Number	Compliance Year	THE RESERVE AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE P	Premium Gr Amount		Payment From					
Number		777	d)		Number	Rate Tables	Percent		Payment		
	S087025	1	\$ 6,00		15	\$	20 %	\$	1,200.00		
The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or reasons:											
The policy is issued for only part of a year and the surcharge was prorated based on the number of days divided by 365. The proration (rounded to the nearest whole percent) was %.											
The policy is a unique part-time policy issued by the primary professional liability insurer (requires explanation belowunder											
This Kansas resident health care provider has an active Missouri license											
The applicable Missouri modification factor was included in the surcharge calculation and the factor used was Type of Primary Coverage Professional Liability Insurance Policy: Occurrence Claims Made											
Insurance Crams Made											
Company Name:											
Name of Agent or Other Company Representative: Sara Patry Policy Number: KSP0024050											
Agent or Company Rep. Email Address: SPATRY@KAMMCO.COM Coverage Eff						tive Date: 08/15/2	2022				
Agent or Company R		Coverage Expiration Date: 08/15/2023									
				Cove	rage Expir	anon Date,					
For insurer explanation of extraordinary circumstances:					FOR HCSF USE ONLY						

Division of Public Health Curtis State Office Building 1000 SW Jackson St., Suite 330 Topeka, KS 66612-1368



Phone: 785-296-0127 Fax: 785-559-4250 www.kdhe.ks.gov/facilities_licensing

Laura Kelly, Governor

3/

Janet Stanek, Secretary

April 10, 2023

Schaunta James-Boyd, Administrator South Wind Women's Center, LLC 5107 East Kellogg Drive Wichita, KS 67218

Re: The Medical Care Facilities - Annual Renewal Report Forms

Dear Mr. James-Boyd,

Enclosed is the Medical Care Facility Annual Report and the Hospital/CAH Database Worksheet or the Ambulatory Surgical Center Update Information Forms. They must be completed, signed and returned to our licensing agency within 30 days from the date on this letter. Please check to assure all elements for the renewal applications are submitted.

As a medical care facility licensee, you need to remain in compliance with the Health Care Provider Insurance Availability Act (KSA 40-3401 et seq.) which requires all medical care facilities licensed by the Kansas Department of Health and Environment to maintain professional liability insurance. Please provide this office the name of the insurance company providing professional liability coverage on behalf of the facility. The declaration page should include your hospital/ASC policy number and the effective dates of the coverage.

In accordance with KSA 65-4922 and KAR 28-52-1, an annual Risk Management Plan (RMP) submission is required for all medical care facilities licensed by the Kansas Department of Health and Environment. The RMP needs to be submitted to KDHE 60-90 days prior to the renewal of the medical care facility licensure. The preferred method of submission is via email to kdhe.riskmanagement@ks.gov. The RMP must be complete and approved by KDHE prior to the renewal of the medical care facility licensure.

If the medical care facility is registered with the Kansas Business Center, please submit the Certificate of Good Standing, you can obtain the certificate at the BESS Website at https://www.kansas.gov/bess/flow/main?execution=e4s1.

Return all applicable documentation, the renewal application, Hospital/CAH or ASC database worksheet, insurance declaration page along with any supporting documentation to Health Facilities Program to complete the medical care facility annual review process.

Email Annual Renewal Report Forms to:
lois.wilkins@ks.gov and Debi.Thompson@ks.gov
Bureau of Facilities and Licensing
Health Facilities Program
1000 SW Jackson Street, Suite 330
Topeka, KS 66612-1365
Office phone: (785) 296-0127

Jerry Smith, LSCSW Bureau Director Bureau of Facilities and Licensing

Enclosures