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

Enclosure

☒ 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)
LICENSE APPLICATION FOR MEDICAL CARE FACILITY

Initial July 25, 2014

DIVISION OF HEALTH

I. IDENTIFICATION:

A. Classification of License Requested: ☐General Hospital ☒ASC ☐Critical Access Hospital ☐Special Hospital

B. Name of Facility: South Wind Women's Center, LLC **(Email)** jburkhart@itrustwomen.org

C. Facility Address: 5107 E Kellogg Dr. City Wichita Zip ~~KS~~ 67218

D. Chief Executive Officer: Julie A. Burkhart Phone 316.425.3215 Fax 316.425.3451

II. CONTROL AND GOVERNING AUTHORITY

A. Disclosing Entity's Name: South Wind Women's Ctr, LLC Address 5107 E. Kellogg, Wichita, KS 67218

B. Type of Entity ☐ 1. Sole Proprietorship ☐ 2. Partnership ☐ 3. Joint Venture ☐ 4. Corporation for profit ☐ 5. Corporation not for profit

☐ 6. Government - Type ____ ☐ 7. Other (Explain) ____ ☒ 8. Limited Liability Company

COMPLETE THE BOXES BELOW WITH THE INFORMATION AS FOLLOWS FOR THE DISCLOSING ENTITY LISTED ON LINE A. ABOVE.

1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or 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 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).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. 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.	5. ELECTED OFFICIALS	(or Attachment) Please See Attached Sheet			

MEDICAL PROGRAM
FEB 28 2013
HEALTH FACILITIES

Do Not Write Below This Line Agency Use Only

Effective Date July 25, 2014

Renewal Date May 1, 2015

License ID No. S 087-025

Approved By A. Jirik

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 6

C. Total Number of All Categories of Medical Staff 6

D. Check the ONE box that applies:

- ☒ The applicant is licensed only (initial application)
- ☐ 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.

- ☒ surgery department
- ☐ obstetrical department
- ☐ pediatric department
- ☒ outpatient 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
- ☐ radiology

G. 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 ______________________________

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] CEO — Julie A. Burkhart

Signature | Title | Print Name

316.425.3215 — 26 Feb 2013

Telephone Number | Date

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
Topeka, Kansas 66612

Phone Number (785) 296-1258 Fax Number (785) 291-3419

Form Hospital 200 (Rev 07/12)

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 Description :	(RN) Registered Nurse
Original Issue Date :	10/24/1988
Expiration :	11/30/2014
Status :	Active
Alert List :	

Risk Manager

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

The **Kansas.gov (http://www.kansas.gov/)** 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: burkhart.julie@gmail.com on behalf of Julie Burkhart <jburkhart@itrustwomen.org>
Sent: Thursday, July 31, 2014 11:29 AM
To: Lois Wilkins
Subject: Re: TW Board Members. One more question?

Lois,

Thank you. I am not a nurse.

Our Director of Nursing - Elizabeth Gomes is our RN/Risk Manager

KS License # 59351

Please let me know if you need anything else. Julie

On Thu, Jul 31, 2014 at 11:09 AM, Lois Wilkins <LWilkins@kdheks.gov> wrote:

Ms. Burkhart,

Are you a nurse? If not whom shall I list as the RN/Risk Manager or someone with medical credentials for our data base?

Thank you,

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

SOUTH WIND WOMEN'S CENTER LLC

File Name Change Online

Business Entity ID Number

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

Disclosing Entity Owned by Trust Women

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: 12/2013

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

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

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

Owner of South Wind

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

☐ 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)
LICENSE APPLICATION FOR MEDICAL CARE FACILITY

July 2015

DIVISION OF HEALTH

I. IDENTIFICATION:

A. Classification of License Requested: ☐General Hospital ☒ASC ☐Critical Access Hospital ☐Special Hospital

B. Name of Facility: SOUTH WIND WOMEN'S CENTER **(Email)**

C. Facility Address: 5107 E Kellogg Drive City Wichita Zip 67218

D. Chief Executive Officer: Julie Burkhart Phone 316-425-3215 Fax 316-425-3451

II. CONTROL AND GOVERNING AUTHORITY

A. Disclosing Entity's Name: TRUST WOMEN FOUNDATION Address 5107 E Kellogg Dr Wichita, KS 67218

B. Type of Entity ☐ 1. Sole Proprietorship ☐ 2. Partnership ☐ 3. Joint Venture ☐ 4. Corporation for profit ☒ 5. Corporation not for profit

☐ 6. Government - Type ______ ☐ 7. Other (Explain) ______ ☐ 8. Limited Liability Company

COMPLETE THE BOXES BELOW WITH THE INFORMATION AS FOLLOWS FOR THE DISCLOSING ENTITY LISTED ON LINE A. ABOVE.

1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or 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 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).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. 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.	5. ELECTED OFFICIALS	(or Attachment) Attachment		KDHE JUN 1 - 2015 Health Facilities Program	
		X						

Do Not Write Below This Line Agency Use Only

Effective Date July 1, 2015 **License ID No.** S087025

Renewal Date May 1, 2016 **Approved By** LW

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 4

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 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.

- ☒ Surgery department
- ☐ Obstetrical department
- ☐ Pediatric department
- ☒ Outpatient 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
- ☐ Radiology

G. 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 _______________

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] CEO — Julie A. Burkhart

Signature / Title — Print Name

316.260.6934 — 28 May 2015

Telephone Number — Date

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
Topeka, Kansas 66612

Phone Number (785) 296-1258 — Fax Number (785) 291-3419

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

CHERYL CHASTINE MD DIRECTO

EXPIRATION DATE

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
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.

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

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: 12/2015

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

Forfeiture Date: 09/15/2017

Close Your Business

Business Entity Search

Date: 06/29/2016

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

SOUTH WIND WOMEN'S CENTER LLC

File Name Change Online

Business Entity ID Number

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: 12/2015

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

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

Susan Mosier, MD, Secretary
Department of Health & Environment
Sam Brownback, Governor

June 29, 2016

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

July 2016

☐ 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)
LICENSE APPLICATION FOR MEDICAL CARE FACILITY

DIVISION OF HEALTH

I. IDENTIFICATION:

A. Classification of License Requested: ☐General Hospital ☒ASC ☐Critical Access Hospital ☐Special Hospital

B. Name of Facility: South Wind Women's Center **(Email)** admin@southwindwomenscenter.org

C. Facility Address: 5107 E. Kellogg Dr. City Wichita Zip 67218

D. Chief Executive Officer: Julie Burkhart Phone 316.260.6934 Fax 316.425.3451

II. CONTROL AND GOVERNING AUTHORITY

A. Disclosing Entity's Name: Trust Women Foundation Address 5107 E. Kellogg Dr. 67218

B. Type of Entity ☐ 1. Sole Proprietorship ☐ 2. Partnership ☐ 3. Joint Venture ☐ 4. Corporation for profit ☒ 5. Corporation not for profit

☐ 6. Government - Type ____ ☐ 7. Other (Explain) ____ ☐ 8. Limited Liability Company

COMPLETE THE BOXES BELOW WITH THE INFORMATION AS FOLLOWS FOR THE DISCLOSING ENTITY LISTED ON LINE A. ABOVE.

1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or 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 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).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. Owner	2. 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)			
		X			Attachment			

KDHE
JUN 15 2016
Health Facilities Program

Do Not Write Below This Line Agency Use Only

Effective Date 7-1-2016 **License ID No.** S087025

Renewal Date 5-1-2017 **Approved By** LW

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 4

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 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.

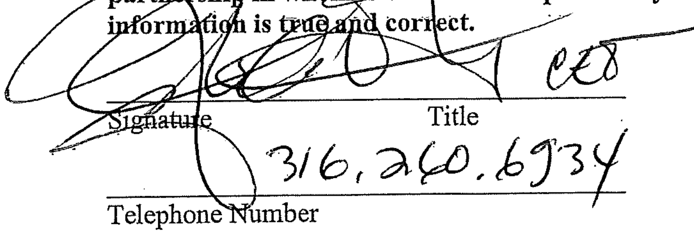
- ☒ Surgery department
- ☐ Obstetrical department
- ☐ Pediatric department
- ☒ Outpatient department
- ☐ Psychiatric department
- ☐ Physical therapy department
- ☐ Inhalation/respiratory therapy department
- ☐ Dialysis
- ☐ Social services department
- ☐ Occupational therapy department
- ☐ Tuberculosis treatment
- ☐ Alcoholism treatment
- ☐ Intensive/coronary care units
- ☐ Long-term care units
- ☐ Radiology

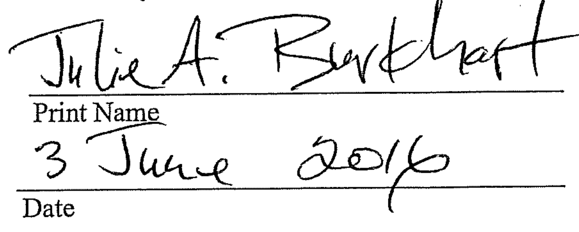
G. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate or waiver?

☒ YES If yes, please attach copy a of the Certificate of Registration

☐ NO Contractor's CLIA number ____________________

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	Title: CEO	Print Name: Julie A. Burkhart
Telephone Number: 316.260.6934		Date: 3 June 2016

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
Topeka, Kansas 66612

Phone Number (785) 296-1258 Fax Number (785) 291-3419

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

SOUTH WIND WOMEN'S CENTER LLC

File Name Change Online

Business Entity ID Number

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

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

CLIA ID NUMBER

17D2056639

EFFECTIVE DATE

11/12/2014

LABORATORY DIRECTOR

CHERYL CHASTINE MD DIRECTO

EXPIRATION DATE

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

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.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0266

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

(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.

CMS Certification Number	State/County Code	State Region Code
S087025 (AS1)	(AS2)	(AS3)

I. IDENTIFYING INFORMATION

- Name of Facility: South Wind Women's Center
- Street Address: 5107 E. Kellogg Dr, 67218
- City, County, and State: Wichita, KS
- Zip Code: 67218
- Telephone No. *(Include Area Code)*: 316.260.6934 (AS4)

II. TYPE OF CONTROL (Check one box) (AS5)

1. ☐ Proprietary 2. ☑ Non-Profit 3. ☐ Government

III. ANCILLARY SERVICES (Place '1' or '2' in blocks) (AS6)

1. ☐ Laboratory 2. ☐ Radiology 3. ☐ Pharmaceutical Services

IV. SURGICAL SPECIALTIES (X appropriate blocks) (AS7)

1. ☐ Dental 2. ☐ Endoscopy 3. ☐ Ear/Nose/Throat
4. ☑ Ob/Gyn 5. ☐ Ophthalmologic 6. ☐ Orthopedic
7. ☐ Pain 8. ☐ Plastic/reconstructive 9. ☐ Podiatry
10. ☐ Other(Specify) ______

V. FACILITY CHARACTERISTICS

1. Number of Operating Rooms/Procedure Rooms 2 (AS8)
2. Date Center Began Providing Services 7/25/14 (AS9)

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.

Signature of Authorized Official (sign in ink) *(required only for initial certification)*	Title	Date
[signature]	CEO	3 June 2016 (AS10)

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 0938-0266. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, searching 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 improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-377 (12/10)

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

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

Policy Number: KSP0024050

Renews: 08/15/2016

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):
Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 60606

Item 2. Policy Period From 08/15/2015 to 08/15/2016
12:01 A.M. standard time at the address of the Named Insured as stated 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 OF LIABILITY			ADVANCE PREMIUMS
Hospital Professional Liability Insurance	Retroactive Date:	08/15/2014	$	200,000	each claim	$ 6,000.00
			$	600,000	annual aggregate	
			$		deductible	
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability		$		each occurrence	$
	(II) Personal Injury/Advertising 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 01/15), 604 (ED 01/15)					

Total Deposit Premium $ 6,000.00

603 (ED 07/2011)

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

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

Policy Number: KSP0024050

Renews: 08/15/2016

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):

Agent Name & Address
USI Midwest
222 S Riverside Plaza
Chicago, IL 60606

Item 2. Policy Period From 08/15/2015 to 08/15/2016
12:01 A.M. standard time at the address of the Named Insured as stated 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.

Countersigned by ______________________
Authorized Representative

603 (ED 07/2011)

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

SECTION I Individual Health Care Provider's Name, designation of M.D., D.O., D.C., D.P.M. or R.N.A. or the name of the health care provider entity (professional association, partnership, hospital or other health care provider organization).

Health Care Provider's Name: South Wind Women's Center LLC

LAST NAME (OR FULL NAME OF HEALTH CARE PROVIDER ENTITY), FIRST NAME, MIDDLE INITIAL AND PROFESSIONAL DESIGNATION

Resident Address: ______ Daytime Phone Number: ______

City: ______ State: ______ Zip: ______

Business Address of Health Care Provider: 5107 E Kellogg Dr, Wichita, KS 67218

SECTION II **Coverage Limit Selection - First time Health Care Provider Signature Required.**

☐ $100,000/$300,000 ☒ $300,000/$900,000 ☐ $800,000/$2,400,000

Date Signed ______ Health Care Provider Signature ______

NOTE: FUND LIMITS CANNOT BE INCREASED USING THIS FORM. ALL INCREASES MUST BE APPROVED BY THE BOARD OF GOVERNORS. CONTACT THE HCSF OFFICE FOR THE NECESSARY DOCUMENTS.

SECTION III Insurance Policy Information And Health Care Stabilization Fund Surcharge Payment

					For Fund Classes 1 to 14	For Fund Classes 15 to 21	
HCSF Rate Classification Number	Provider's License, Registration or Certification Number	Basic Coverage Premium Amount	Number of Fund Compliance Years	HCSF Class Group No	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment
	800857801	6,000.00	2	17		35%	2,100.00

KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

ENTER NAME OF INSURANCE COMPANY

Sara Patry

NAME OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

(785) 232-4740

TELEPHONE NUMBER OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or reasons:

☐ THE POLICY IS SUBJECT TO A PART-TIME PRACTICE CREDIT RATING RULE APPROVED FOR USE BY THE BASIC PROFESSIONAL LIABILITY INSURER. THE PART-TIME FACTOR USED WAS ______

☐ THIS KANSAS RESIDENT HEALTH CARE PROVIDER HAS AN ACTIVE MISSOURI LICENSE AND THE 30% MODIFICATION FACTOR WAS INCLUDED IN THE ABOVE SURCHARGE.

Policy Number: KSP0024050

Type of Basic Coverage Professional Liability Policy
☐ Occurrence ☒ Claims Made

Inception Date: 08/15/2015
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

Coverage Effective Date: 08/15/2015
ENTER DATE THIS HEALTH CARE PROVIDER WAS ADDED TO AN EXISTING POLICY PERIOD

Expiration Date: 08/15/2016
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

FOR HCSF USE ONLY

Notice to Health Care Provider: If you should discontinue your basic professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact the Kansas Health Care Stabilization Fund Board of Governors and request information regarding the availability of the Health Care Stabilization Fund's continuing coverage for inactive health care providers.

FOR HCSF USE ONLY

FOR HCSF USE ONLY

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

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

Initial
(Renewal) [circled]
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)
LICENSE APPLICATION FOR MEDICAL CARE FACILITY

July 2017

DIVISION OF HEALTH

I. IDENTIFICATION:

A. Classification of License Requested: General Hospital (ASC) [circled] Critical Access Hospital Special Hospital

B. Name of Facility: South Wind Women's Center (Email) admin@southwindwomenscenter.org

C. Facility Address: 5107 E. Kellogg DR. City Wichita Zip 67218

D. Chief Executive Officer: Julie Burkhart Phone 316.260.6934 Fax 316.425.3451

II. CONTROL AND GOVERNING AUTHORITY

A. Disclosing Entity's Name: Trust Women Foundation Address 5107 E. Kellogg DR. Wichita, KS 67218

B. Type of Entity 1. Sole Proprietorship 2. Partnership 3. Joint Venture 4. Corporation for profit (5. Corporation not for profit) [circled]

6. Government - Type ________ 7. Other (Explain) ________ 8. Limited Liability Company

COMPLETE THE BOXES BELOW WITH THE INFORMATION AS FOLLOWS FOR THE DISCLOSING ENTITY LISTED ON LINE A. ABOVE.

1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or 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 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).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. 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.	5. ELECTED OFFICIALS	(or Attachment)		Health Facilities Program MAY 26 2017 KDHE	
		X			Attached.			

Do Not Write Below This Line Agency Use Only

Effective Date July 1, 2017 **License ID No.** S087025

Renewal Date July 1, 2018 **Approved By** LW

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 4

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 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.

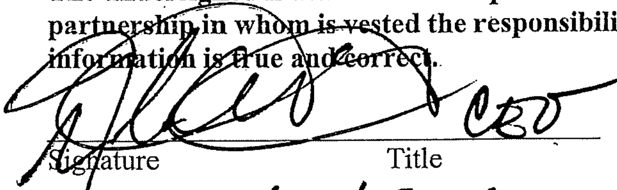
- ☐ Surgery department
- ☐ Obstetrical department
- ☐ Pediatric department
- ☐ Outpatient department
- ☐ Psychiatric department
- ☐ Physical therapy department
- ☐ Inhalation/respiratory therapy department
- ☐ Dialysis
- ☐ Social services department
- ☐ Occupational therapy department
- ☐ Tuberculosis treatment
- ☐ Alcoholism treatment
- ☐ Intensive/coronary care units
- ☐ Long-term care units
- ☐ Radiology

G. 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 _______________

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 | Title: CEO

Print Name: Julie A. Burkhart

Telephone Number: 316.260.6934

Date: 23 May 2017

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
Topeka, Kansas 66612

Phone Number (785) 296-1258 Fax Number (785) 291-3419

Business Entity Search

Date: 06/19/2017

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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

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.

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

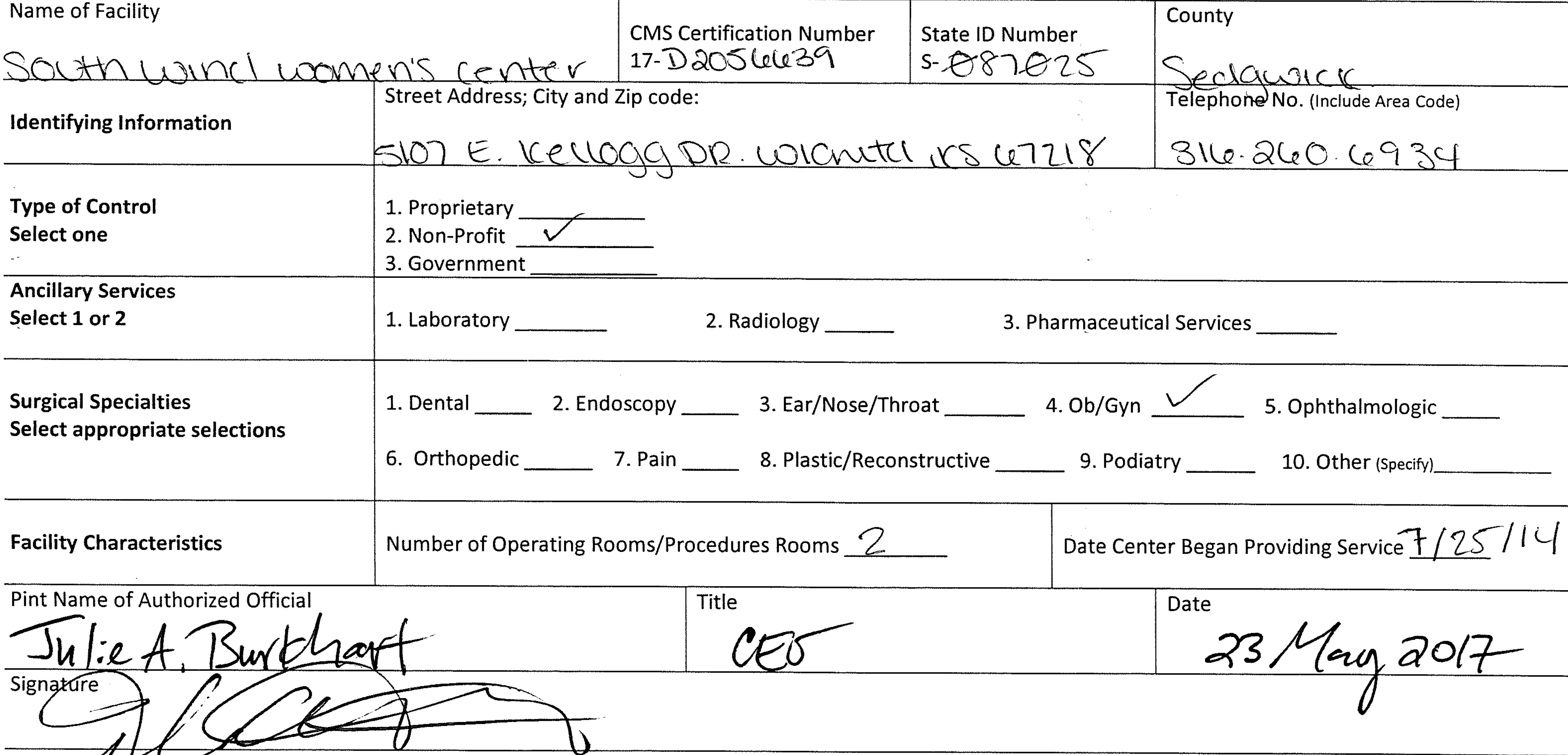
220 Certs2_101816

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)	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.



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	CMS Certification Number: 17-D2056639	State ID Number: S-087025	County: Sedgwick
Identifying Information	Street Address; City and Zip code: 5107 E. Kellogg DR. Wichita KS 67218		Telephone No. (Include Area Code): 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 ____		
Surgical Specialties **Select appropriate selections**	1. Dental ____ 2. Endoscopy ____ 3. Ear/Nose/Throat ____ 4. Ob/Gyn ✓ 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 7/25/14	
Pint Name of Authorized Official: Julie A. Burkhart	Title: CEO	Date: 23 May 2017	
Signature: [signature]			

Flip this Page for Part II

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

Department of Health & Environment

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

Susan Mosier, MD, Secretary

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

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

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

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

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

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

Initial
Renewal (circled)
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)
LICENSE APPLICATION FOR MEDICAL CARE FACILITY

July 2018

DIVISION OF HEALTH

I. IDENTIFICATION:

A. Classification of License Requested: General Hospital (ASC) Critical Access Hospital Special Hospital

B. Name of Facility: South Wind Women's Center (Email) ________

C. Facility Address: 5107 E Kellogg Drive City Wichita Zip 67218

D. Chief Executive Officer: Julie Burkhart Phone 316 425 3215 Fax 316 425 3451

II. CONTROL AND GOVERNING AUTHORITY

A. Disclosing Entity's Name: Trust Women Foundation Address 5107 E Kellogg Dr Wichita KS 67218

B. Type of Entity 1. Sole Proprietorship 2. Partnership 3. Joint Venture 4. Corporation for profit (5. Corporation not for profit)

6. Government - Type ________ 7. Other (Explain) ________ 8. Limited Liability Company

COMPLETE THE BOXES BELOW WITH THE INFORMATION AS FOLLOWS FOR THE DISCLOSING ENTITY LISTED ON LINE A. ABOVE.

1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or 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 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).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. 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.	5. ELECTED OFFICIALS	(or Attachment)			
		X			Attachment			

KDHE
MAY - 4 2018
Health Facilities Program

Do Not Write Below This Line Agency Use Only

Effective Date 7-1-18

Renewal Date 7-1-19

License ID No. S082025

Approved By LW

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

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

CLIA 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.

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

220 Certs2_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)	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

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 4

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 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.

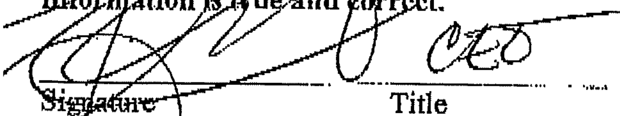
- ☐ Surgery department
- ☐ Obstetrical department
- ☐ Pediatric department
- ☐ Outpatient department
- ☐ Psychiatric department
- ☐ Physical therapy department
- ☐ Inhalation/respiratory therapy department
- ☐ Dialysis
- ☐ Social services department
- ☐ Occupational therapy department
- ☐ Tuberculosis treatment
- ☐ Alcoholism treatment
- ☐ Intensive/coronary care units
- ☐ Long-term care units
- ☐ Radiology

G. 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 ________________

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.



CEO

Signature Title

Julie A Burkhart

Print Name

316 260 6934

Telephone Number

4 May 2018

Date

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
Topeka, Kansas 66612

Phone Number (785) 296-1258 Fax Number (785) 559-4250

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 :e.

: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 ırce, place a '2' on the appropriate line. **If the service is not provided at this ASC enter N/A, please do not leave any blank spaces on this form.*

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

ne of Facility outh Wind Women's Center	CMS Certification Number 17-	State ID Number S-087025	County Sedgwick
ntifying Information	Street Address; City and Zip code: 5107 E Kellogg Drive Wichita 67218		Telephone No. (Include Area Code) 316 260 6934
e of Control **:ct one**	1. Proprietary ____ 2. Non-Profit ✓ 3. Government ____		
:illary Services **:ct 1 or 2** ***N/A***	1. Laboratory ____ 2. Radiology ____ 3. Pharmaceutical Services ____		
gical Specialties **:ct appropriate selections**	1. Dental ____ 2. Endoscopy ____ 3. Ear/Nose/Throat ____ 4. Ob/Gyn ✓ 5. Ophthalmologic ____ 6. Orthopedic ____ 7. Pain ____ 8. Plastic/Reconstructive ____ 9. Podiatry ____ 10. Other (Specify) ____		
ility Characteristics	Number of Operating Rooms/Procedures Rooms 2		Date Center Began Providing Service 4/3/2013
: Name of Authorized Official Julie Burkhart	Title CEO and Founder		Date 4 May 2018
nature [signature]			

Flip this Page for Part II

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 amend, extend, or alter the coverage afforded by the policy below.

POLICY NUMBER: KSP0024050 POLICY HOLDER SINCE: 08/15/2014

FOR THE PERIOD FROM 08/15/2017 12:01a.m. TO 08/15/2018 12:01 a.m.

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 policy of professional liability insurance listed above has been issued to the Health Care Provider named above for the policy period indicated. The insurance afforded by the policy described herein is subject to all the terms, exclusions, and conditions of such professional liability policy. The limits of liability 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 at the date of issuance of this Certificate of Insurance.

LIMITS OF LIABILITY

	KHCPIAP	HCSF Option 2	TOTAL
Each Claim	$200,000	$300,000	$500,000
Annual Aggregate	$600,000	$900,000	$1,500,000

AUTHORIZED REPRESENTATIVE

07/31/2017

DATE OF ISSUE

INSURED COPY

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

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/bhfr

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,

Marilyn 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

July 2019

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 E Kellogg Drive City: Wichita

Zip Code: 67218 Public Phone: 316 2606934 Fax: 316 4253?

Web Address: www.trustwomen.org

** Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:*

Health Facilities Program
MAY 29 2019
KDHE

Days Open: M – F Operation Hours: 8-5

Administration Information:

C. Chief Executive Officer: Julie Burkhart

Desk phone 316 425 3215 Email address jburkhart@itrustwomen.org

* Chief of Medical Staff: Colleen McNicholas

Email address: mcnicholasc@wustl.edu Phone: ___________

* Director *or* Risk Manager Name: Christie Burkhart

Email address: cburkhart@itrustwomen.org Phone: 316 425 3215

Do Not Write Below This Line, State Agency Use Only

Effective Date July 25, 2014 Facility I.D. Number S087025

Renewal Date July 25, 2019 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 Women Foundation

Physical Address: 5107 E Kellogg Dr Wichita KS 67218
City/State Zip code

B. *Type of Entity:* ☐ Corporation for profit ☒ Corporation non-profit

☐ Limited Liability Company (LLC) ☐ Professional Associates (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

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

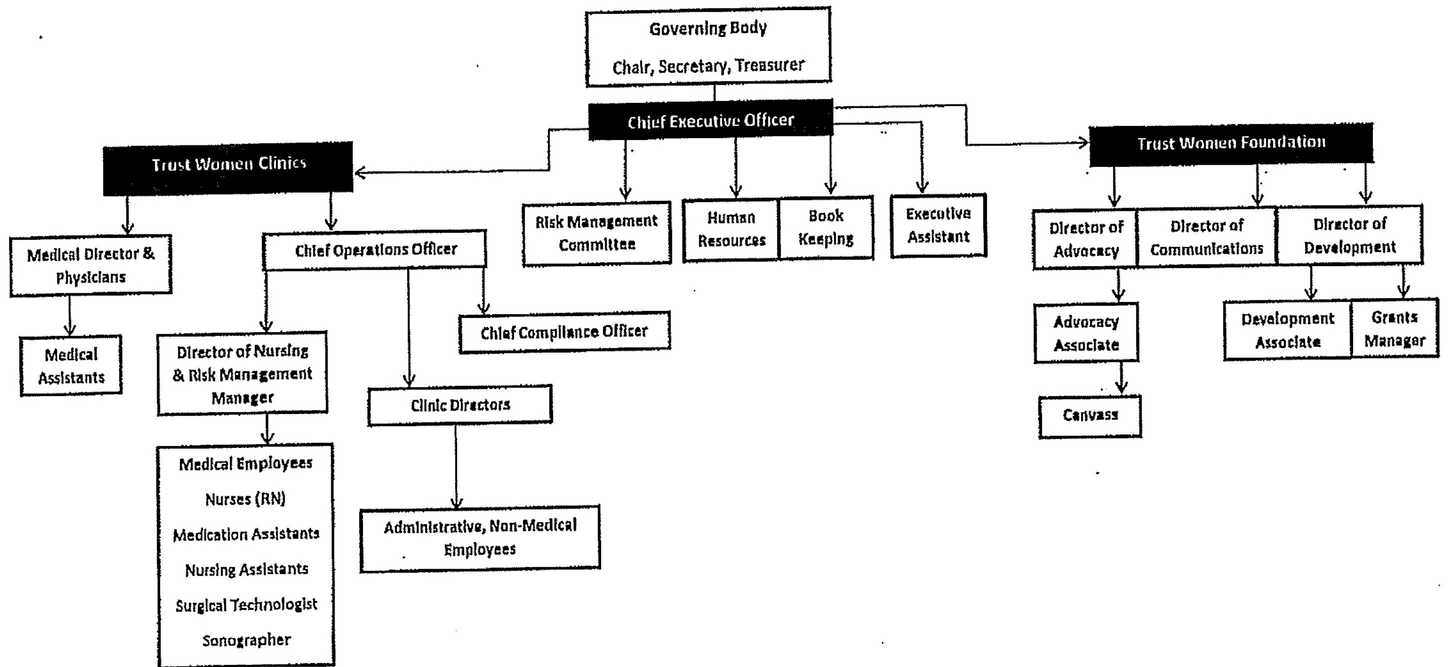
The Last Annual Report on File: 12/2018

Next Annual Report Due: 06/15/2020

Forfeiture Date: 09/15/2020

Trust Women Foundation & Trust Women Clinics

Organizational Chart



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 Information:

A. ***(FOR HOSPITALS ONLY)*** Number of Beds: General beds ______ Observation beds _____

Swing beds _______ IPPS beds _______ LTC ______ Bassinets _______

B. Number of Active Medical Staff 4

C. ***Check the box that applies:***

- [x] This applicant is licensed only
- [ ] This applicant is licensed, accredited
- [ ] This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization ______________________ and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates ________________________________

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

- [ ] Surgery department
- [ ] Obstetrical department
- [x] Outpatient department
- [ ] Pediatric department
- [ ] Long Term Care Unit
- [ ] Intensive coronary care units
- [ ] Radiology
- [ ] Social Services
- [ ] Psychiatric Services
- [ ] Dialysis Services
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate YES, please submit copy a of the current CLIA Certificate of Registration.

(Initials) _________ I 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.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

Julie Burkhart — Print Name

CEO/Founder — Title

[signature] — Signature

316 425 3215 — Phone number

29/May 2019 — Date

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 completed application & documentation: Kansas Department of Health and Environment
Bureau of Community Health Systems
Health Facilities Program
1000 SW Jackson St., Suite 330
Topeka, Kansas 66612
Phone Number (785) 296-1258 email to lois.wilkins@ks.gov Fax Number (785) 559-4250

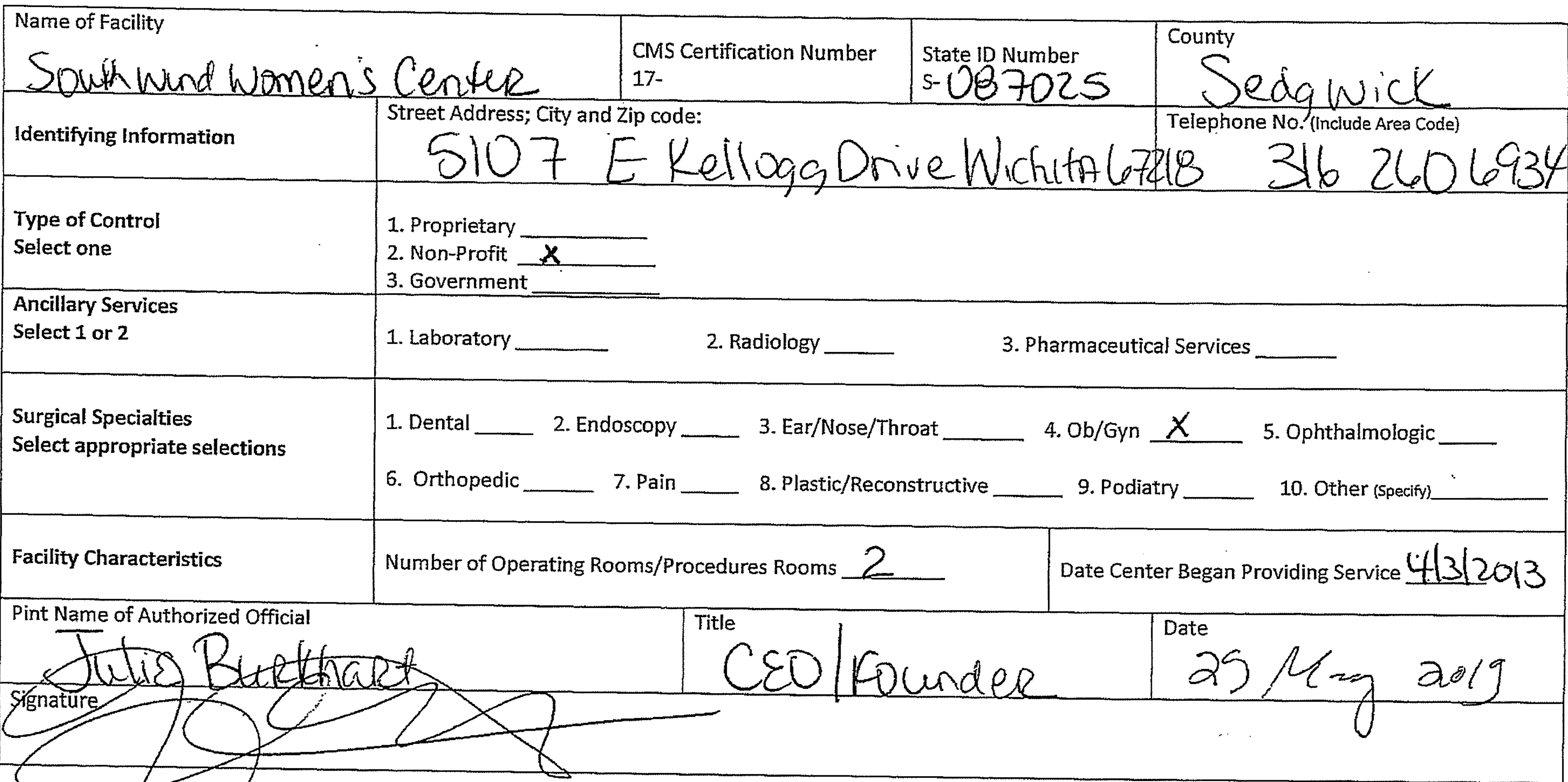
Ambulatory Surgery Center Updated Information

(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 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	CMS Certification Number: 17-	State ID Number: S-087025	County: Sedgwick
Identifying Information	Street Address; City and Zip code: 5107 E Kellogg Drive Wichita 67218		Telephone No. (Include Area Code): 316 260 6934
Type of Control Select one	1. Proprietary ___ 2. Non-Profit X 3. Government ___		
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 4/3/2013	
Pint Name of Authorized Official: Julie Burkhart	Title: CEO/Founder	Date: 25 May 2019	
Signature: [signature]			

Flip this Page for Part II

Revised by HFP 6.2016

AMBULATORY SURGICAL CENTER SURVEY REPORT

CRUCIAL DATA EXTRACT

	YES	NO
1. Emergency Call Lights	✓	
2. Oxygen	✓	
3. Mechanical ventilatory assistance equipment		
4. Cardiac defibrillator	✓	
5. Cardiac monitoring equipment		
6. Tracheostomy set		
7. Laryngoscopes and endotracheal tubes		
8. Suction equipment	✓	
9. Emergency medical equipment & supplies	✓	

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 amend, extend, or alter the coverage afforded by the policy below.

POLICY NUMBER: KSP0024050 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 AND ADDRESS OF CERTIFICATE HOLDER:

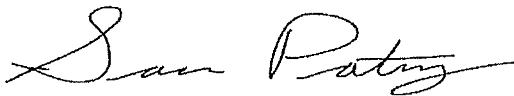
NAME AND ADDRESS OF HEALTH CARE PROVIDERS:

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

This is to certify that the policy of professional liability insurance listed above has been issued to the Health Care Provider named above for the policy period indicated. The insurance afforded by the policy described herein is subject to all the terms, exclusions, and conditions of such professional liability policy. The limits of liability 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 at the date of issuance of this Certificate of Insurance.

LIMITS OF LIABILITY

	KHCPIAP	HCSF Option 2	TOTAL
Each Claim	$200,000	$300,000	$500,000
Annual Aggregate	$600,000	$900,000	$1,500,000



AUTHORIZED REPRESENTATIVE

08/07/2018
DATE OF ISSUE

KSP116-1 (ED 01/93)

INSURED COPY

HOSPITAL PROFESSIONAL LIABILITY PROGRAM

Declarations-Claims Made

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

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

Policy Number: KSP0024050

Renews: 08/15/2019

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):

Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 60606

Item 2. Policy Period From 08/15/2018 to 08/15/2019
12:01 A.M. standard time at the address of the Named Insured as stated 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 OF LIABILITY		ADVANCE PREMIUMS
Hospital Professional Liability Insurance	Retroactive Date: 08/15/2014	$ 200,000	each claim	$ 6,000.00
		$ 600,000	annual aggregate	
		$	deductible	
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability	$	each occurrence	$
	(II) Personal Injury/Advertising 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

Countersigned by [signature]

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

Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

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
Fax: 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,

Marilyn 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 E Kellogg Drive City: Wichita

Zip Code: 67218 Public Phone: 316 260 6934 Fax: 316 425 3451

Web Address: wichita@trustwomen.org
trustwomen.org

* *Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:*

Days Open: Monday – Friday Operation Hours: 08:00am - 5:00pm

Administration Information:

C. Chief Executive Officer: Julie A Burkhart

Desk phone 316 425 3215 Email address jburkhart@trustwomen.org

* Chief of Medical Staff: Juliet W Marsh

Email address: julesmarsh@hush.com Phone: 316 260 6934

* Director *or* Risk Manager Name: Christie Burkhart

Email address: cburkhart@trustwomen.org Phone: 316 425 3215

Do Not Write Below This Line, State Agency Use Only

Effective Date 07-01-05 Facility I.D. Number H064001

Renewal Date 07-01-20 Reviewed By DianyJ 7.24.20

***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: Trust Women Foundation

Physical Address: 5107 E Kellogg Drive Wichita KS 67218
City/State Zip code

B. *Type of Entity:* ☐ Corporation for profit ☒ Corporation non-profit

☐ Limited Liability Company (LLC) ☐ Professional Associates (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: General beds ______ Observation beds _____

Swing beds _______ IPPS beds _______ LTC ______ Bassinets _______

B. Number of Active Medical Staff 4

C. ***Check the box that applies:***

- [x] This applicant is licensed only
- [ ] This applicant is licensed, accredited
- [ ] This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization ______________________ and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates ______________________________

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

- [ ] Surgery department
- [ ] Obstetrical department
- [x] Outpatient department
- [ ] Pediatric department
- [ ] Long Term Care Unit
- [ ] Intensive coronary care units
- [ ] Radiology
- [ ] Social Services
- [ ] Psychiatric Services
- [ ] Dialysis Services
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate YES, please submit copy a of the current CLIA Certificate of Registration.

(Initials) JB I 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.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

Julie A Burkhart Founder &CEO
Print Name Title

[signature]
Signature

316 425 3215
Phone number

3 June 2025
Date

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 completed application & documentation: Kansas Department of Health and Environment
Bureau of Community Health Systems
Health Facilities Program
1000 SW Jackson St., Suite 330
Topeka, Kansas 66612
email to lois.wilkins@ks.gov

Phone Number (785) 296-1258 Fax Number (785) 559-4250

HOSPITAL PROFESSIONAL LIABILITY PROGRAM

Declarations-Claims Made

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

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

Policy Number: KSP0024050

Renews: 08/15/2020

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):

Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 60606

Item 2. Policy Period From 08/15/2019 to 08/15/2020
12:01 A.M. standard time at the address of the Named Insured as stated 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.

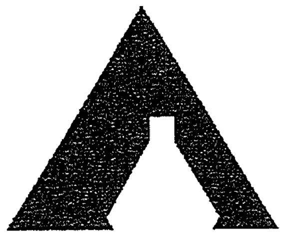
COVERAGE PARTS	COVERAGES	LIMITS OF LIABILITY			ADVANCE PREMIUMS
Hospital Professional Liability Insurance	Retroactive Date: 08/15/2014	$	200,000	each claim	$ 6,000.00
		$	600,000	annual aggregate	
		$		deductible	
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability	$		each occurrence	$
	(II) Personal Injury/Advertising 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

Countersigned by [signature]

Authorized Representative

603 (ED 07/2011)



American
Proficiency
Institute

PROFICIENCY TESTING SERVICE

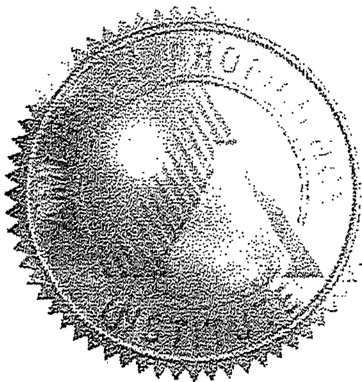
2020

CERTIFICATE OF PARTICIPATION

This certifies

S. Wind Women's Center

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



Dan Edson

Daniel C. Edson, President

Lois Wilkins [KDHE]

From: Lois Wilkins [KDHE]
Sent: Friday, July 10, 2020 11:39 AM
To: Christie Burkhart
Cc: Lois Wilkins [KDHE]
Subject: 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.

Dan Edson

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 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		CMS Certification Number 17- 441271	State ID Number S-	County Sedgwick
Identifying Information	Street Address; City and Zip code: 5107 E Kellogg Dr Wichita 67218			Telephone No. (Include Area Code) 316 260 6934
Type of Control **Select one**	1. Proprietary ____ 2. Non-Profit X 3. Government ____			
Ancillary Services **Select 1 or 2**	1. Laboratory X 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 4/3/2013
Pint Name of Authorized Official Julie Burkhart		Title Founder & CEO		Date 23 July 2025
Signature [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

Laura Kelly, Governor

June 26, 2024

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

DocuSign Envelope ID: F7D15C3D-80FB-4EE3-8AF7-CE7C51A94878

July 2024

Select One
- [ ] Initial
- [x] Annual Renewal
- [ ] Change of Owner
- [ ] 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:*** [x] 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

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 S087025

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).

II. CONTROL AND GOVERNING AUTHORITY:

A. Disclosing Entity's Name: South Wind Women's Center LLC

Physical Address: 5107 E. Kellogg Drive — City/State: Wichita, KS — Zip code: 67218

B. *Type of Entity:*

- ☐ Corporation for profit
- ☑ Corporation non-profit
- ☐ Limited Liability Company (LLC)
- ☐ Professional Associates (P.A.)
- ☐ Government/County __________
- ☐ Other (Explain) __________

Print Name	Title	Ownership %	Address
Jessica Wannemacher	Acting Administrat[illegible]	N/A	Same
Trust Women Foundation Inc.	Owner	100%	Same
Sapphire Garcia-Lies	President	N/A	Same
Susan Edgerley	Secretary	N/A	Same
Bruce Price	Director	N/A	Same
Keyla Harrison	Director	N/A	Same

General Information:

A. ***(FOR HOSPITALS ONLY)*** Number of Beds: General beds ______ Observation beds _____

Swing beds _______ IPPS beds _______ LTC _______ Bassinets _______

B. Number of Active Medical Staff 7

C. ***Check the box that applies:***

- [x] This applicant is licensed only
- [ ] This applicant is licensed, accredited
- [ ] This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization N/A and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates N/A

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

- [ ] Surgery department
- [ ] Obstetrical department
- [ ] Outpatient department
- [ ] Pediatric department
- [ ] Long Term Care Unit
- [ ] Intensive coronary care units
- [ ] Radiology
- [ ] Social Services
- [ ] Psychiatric Services
- [ ] Dialysis Services
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate 17D2056639, please submit copy a of the current CLIA Certificate of Registration.

(Initials) JW I 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.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

Jessica Wannemacher	Acting Administrator	DocuSigned by: Jessica Wannemacher
Print Name	Title	Signature
316-260-6934		6/20/2024
Phone number		Date

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 completed application with supporting documentation** to: kdhe.bfla@ks.gov

Email: kdhe.bfla@ks.gov
Bureau of Facilities and Licensing
1000 SW Jackson St., Suite 330
Topeka,Kansas 66612
Phone Number (785) 296-0127

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

Trust Women Foundation
P.O. Box 3222
Wichita, KS 67201

trustwomen.org

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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.

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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

CLIA ID NUMBER
17D2056639

EFFECTIVE DATE
11/12/2022

LABORATORY DIRECTOR
CHRISTINA M BOURNE M.D.

EXPIRATION DATE
11/11/2024

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
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	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		

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.

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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 17-	State ID Number S- 087025	County Site Sedgwick
Identifying Information	Street Address; City and Zip code: 5107 E. Kellogg Drive, Wichita KS 67218			Telephone No. (Include Area Code) 316-260-6934
Type of Control **Select one**	1. Proprietary ☐ 2. Non-Profit ☑ 3. Government ☐			
Ancillary Services **Select 1 or 2**	1. Laboratory 1	2. Radiology ____	3. Pharmaceutical Services ____	
Surgical Specialties **Select appropriate selections**	1. Dental ☐ 2. Endoscopy ☐ 3. Ear/Nose/Throat ☐ 4. Ob/Gyn ☑ 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 4/3/2013	
Pint Name of Authorized Official Jessica Wannemacher		Title Acting Administrator		Date 6/20/2024
Signature DocuSigned by: Jessica Wannemacher E66368BD3D87470...		Email Address jwannemacher@itrustwomen.org		

Bureau of Faciliies and Licensing 12/2023

DocuSign Envelope ID: F7D15C3D-80FB-4EE3-8AF7-CE7C51A94878

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)

Policy Number: KSP0024050

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

Renews: 08/15/2024

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):

Item 2. Policy Period From 08/15/2023 to 08/15/2024
12:01 A.M. standard time at the address of the Named Insured as stated herein.

Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 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 policy having reference thereto.

COVERAGE PARTS	COVERAGES	LIMITS OF LIABILITY *			ADVANCE PREMIUMS
Professional Liability Insurance	Retroactive Date: 08/15/2014	$	500,000	each claim	$ 6,610.00
		$	1,500,000	annual aggregate	
		$		deductible	

*Notwithstanding the Limits of Liability stated above, 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.

COVERAGE PARTS	COVERAGES	LIMITS OF LIABILITY			ADVANCE PREMIUMS
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability	$		each occurrence	$
	(II) Personal Injury/Advertising 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 01/22), 604 (ED 01/22)				

Total Deposit Premium $ 6,610.00

Countersigned by [signature]
Authorized Representative

SWWC Facility License Renewal Attachment A

603 (ED 01/22)

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.

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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.

FOR HCSF USE ONLY

SECTION I – Health Care Provider Identification and Residency

Health Care Provider's Name: South Wind 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 provider

Health Care Provider's 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 Provider's Email Address:

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

☒ $500,000/$1,500,000

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.*

SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information

HCSF Rate Classification Number	Provider's License Number	Fund Compliance Year	Basic Coverage Premium Amount	HCSF Class Group Number	For Fund Classes 1 to 14: HCSF Surcharge Payment From Rate Tables	For Fund Classes 15 to 24: HCSF Surcharge Percent	For Fund Classes 15 to 24: HCSF % Based Surcharge Payment
	S087025	1	$ 6,610.00	15	$	20 %	$ 1,322.00

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 "extraordinary circumstances"). The part-time factor used was ___ %.

☐ 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 Company Name:

Name of Agent or Other Company Representative: Sara Patry	Policy Number: KSP0024050
Agent or Company Rep. Email Address: SPATRY@KAMMCO.COM	Coverage Effective Date: 08/15/2023
Agent or Company Rep. Phone Number: (785) 232-2224	Coverage Expiration Date: 08/15/2024

For insurer explanation of extraordinary circumstances:

FOR HCSF USE ONLY

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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 08/15/2023 12:01 a.m. TO 08/15/2024 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

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AUTHORIZED REPRESENTATIVE

07/11/2023

DATE OF ISSUE

SWWC Facility License Renewal Attachment A

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

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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.

Attachment A ______ 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 B ______ 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 C ______ 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:	32
Type:	
L Class:	ASC
C Class:	
Facility Address:	5107 EAST KELLOGG DRIVE
Facility City:	WICHITA
County:	SEDGWICK
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:	0
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
Topeka, KS 66612-1365

Phone: 785-296-0127
Fax: 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,

Marilyn 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

July 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 Identification:

A. ***Classification of License select one:*** ☐ General Hospital ☐ Special Hospital ☐ Critical Access Hospital ☒ Ambulatory Surgery Center

B. ***Name of Medical Care Facility:*** South Wind Women's Center

Address: 5107 E Kellogg Drive City: Wichita

Zip Code: 67218 Public Phone: 3162606934 Fax: 316 425 3451

Web Address: www.trustwomen.org

** Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:*

Days Open: Monday - Friday Operation Hours: 08:00am - 5:00 pm

Administration Information:

C. Chief Executive Officer: Julie A Burkhart

Desk phone 316 425 3215 Email address jburkhart@trustwomen.org

* Chief of Medical Staff: Juliet W Marsh

Email address: julesmarsh@hush.com Phone: 316 260 6934

* Director *or* Risk Manager Name: Christie Burkhart

Email address: cburkhart@trustwomen.org Phone: 316 425 3215

see letter on next page

Do Not Write Below This Line, State Agency Use Only

Effective Date 7.25.2014 Facility I.D. Number S087025

Renewal Date 4.1.2021 Reviewed By [signature]

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
  - sjamesboyd@itrustwomen.org

- Rebecca Tong, effective 7/12/2021 is the Co-Chief Executive Officer
  - rtong@itrustwomen.org

- Ashley Brink, effective 7/19/2021 is the Director
  - 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

Anthony Tenbrink, Treasurer

Jessica Wells-Hasan, Secretary

Susan Edgerley

Bruce Price, M.D.

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 Women Foundation

Physical Address: 5107 E Kellogg Drive Wichita, KS 67218
City/State Zip code

B. *Type of Entity:* ☐ Corporation for profit ☒ Corporation non-profit

☐ Limited Liability Company (LLC) ☐ Professional Associates (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: General beds ______ Observation beds _____

Swing beds _______ IPPS beds _______ LTC ______ Bassinets _______

B. Number of Active Medical Staff 4

C. ***Check the box that applies:***

- [x] This applicant is licensed only
- [ ] This applicant is licensed, accredited
- [ ] This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization ______________________ and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates ________________________________

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

- [ ] Surgery department
- [ ] Obstetrical department
- [x] Outpatient department
- [ ] Pediatric department
- [ ] Long Term Care Unit
- [ ] Intensive coronary care units
- [ ] Radiology
- [ ] Social Services
- [ ] Psychiatric Services
- [ ] Dialysis Services
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate YES, please submit copy a of the current CLIA Certificate of Registration.

(Initials) JB I 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.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

Julie A Burkhart Founder & CEO [signature]

Print Name Title Signature

316 425 3215 14 April 2021

Phone number Date

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 completed application & documentation 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

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

Trust Women Foundation
Post Office Box 3222 | Wichita, Kansas 67201 | 316.425.3215 |
www.trustwomen.org

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

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

CLIA ID NUMBER
17D2056639

EFFECTIVE DATE
11/12/2020

LABORATORY DIRECTOR
JULIET MARSH M.D.

EXPIRATION DATE
11/11/2022

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.

Amy M. Zale

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

172 certs2_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 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.

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	CMS Certification Number: 17- 441271	State ID Number: S-	County Site: Sedgwick
Identifying Information	Street Address; City and Zip code: 5107 E Kellogg Drive Wichita 67218		Telephone No. (Include Area Code): 3162606934
Type of Control **Select one**	1. Proprietary ____ 2. Non-Profit X 3. Government ____		
Ancillary Services **Select 1 or 2**	1. Laboratory X	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 4/3/2013
Pint Name of Authorized Official: Julie A Burkhart	Title: Founder & CEO		Date: 14 April 21
Signature			

HOSPITAL PROFESSIONAL LIABILITY PROGRAM
Declarations-Claims Made

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

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

Policy Number: KSP0024050

Renews: 08/15/2021

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):

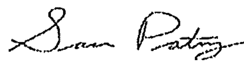
Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 60606

Item 2. Policy Period From 08/15/2020 to 08/15/2021
12:01 A.M. standard time at the address of the Named Insured as stated 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 OF LIABILITY			ADVANCE PREMIUMS
Hospital Professional Liability Insurance	Retroactive Date: 08/15/2014	$	200,000	each claim	$ 6,000.00
		$	600,000	annual aggregate	
		$		deductible	
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability	$		each occurrence	$
	(II) Personal Injury/Advertising 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

Countersigned by 

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

Lee A. Norman, M.D., Secretary

Laura Kelly, Governor

March 29, 2021

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

July 25,

Health Facilities Program
APR 26 2022
KDHE

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 E Kellogg Dr. City: Wichita

Zip Code: 67218-1625 Public Phone: 316-260-6934 Fax: 316-444-0409

Web Address: trustwomen.org

* *Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:*

Days Open: Mon-Sun Operation Hours: 8 AM-5 PM

Administration Information:

C. Chief Executive Officer: Rebecca Tong

Desk phone 316-425-3215 Email address rtong@itrustwomen.org

* Chief of Medical Staff: Christina Bourne, MD

Email address: cbourne@itrustwomen.org Phone: 316-260-6934

* 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 S087025

Renewal Date 7.25.2022 Reviewed By DJ 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 Women Foundation

Physical Address: 5107 E Kellogg Dr. Wichita / KS 67218-1625
City/State Zip code

B. *Type of Entity:* ☐ Corporation for profit ☒ Corporation non-profit

☐ Limited Liability Company (LLC) ☐ Professional Associates (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: General beds ______ Observation beds ______

Swing beds _______ IPPS beds _______ LTC _______ Bassinets _______

B. Number of Active Medical Staff 7

C. ***Check the box that applies:***

- [x] This applicant is licensed only
- [ ] This applicant is licensed, accredited
- [ ] This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization ______________________ and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates ________________________________

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

- [ ] Surgery department
- [ ] Obstetrical department
- [ ] Outpatient department
- [ ] Pediatric department
- [ ] Long Term Care Unit
- [ ] Intensive coronary care units
- [ ] Radiology
- [ ] Social Services
- [ ] Psychiatric Services
- [ ] Dialysis Services
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate yes, please submit copy a of the current CLIA Certificate of Registration.

(Initials) RT I 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.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

Rebecca Tong Co-Executive Director
Print Name Title

[signature]
Signature

316-425-3215
Phone number

4/11/2022
Date

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 completed application & documentation** 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

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS	CLIA ID NUMBER
SOUTH WIND WOMENS CENTER 5107 EAST KELLOGG DRIVE WICHITA, KS 67218	17D2056639
	EFFECTIVE DATE 11/12/2020
LABORATORY DIRECTOR	EXPIRATION DATE
JULIET MARSH M.D.	11/11/2022

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.

Amy M. Zale

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

172 certs2_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 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.

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

SOUTH WIND WOMEN'S CENTER LLC

Business Entity ID Number

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

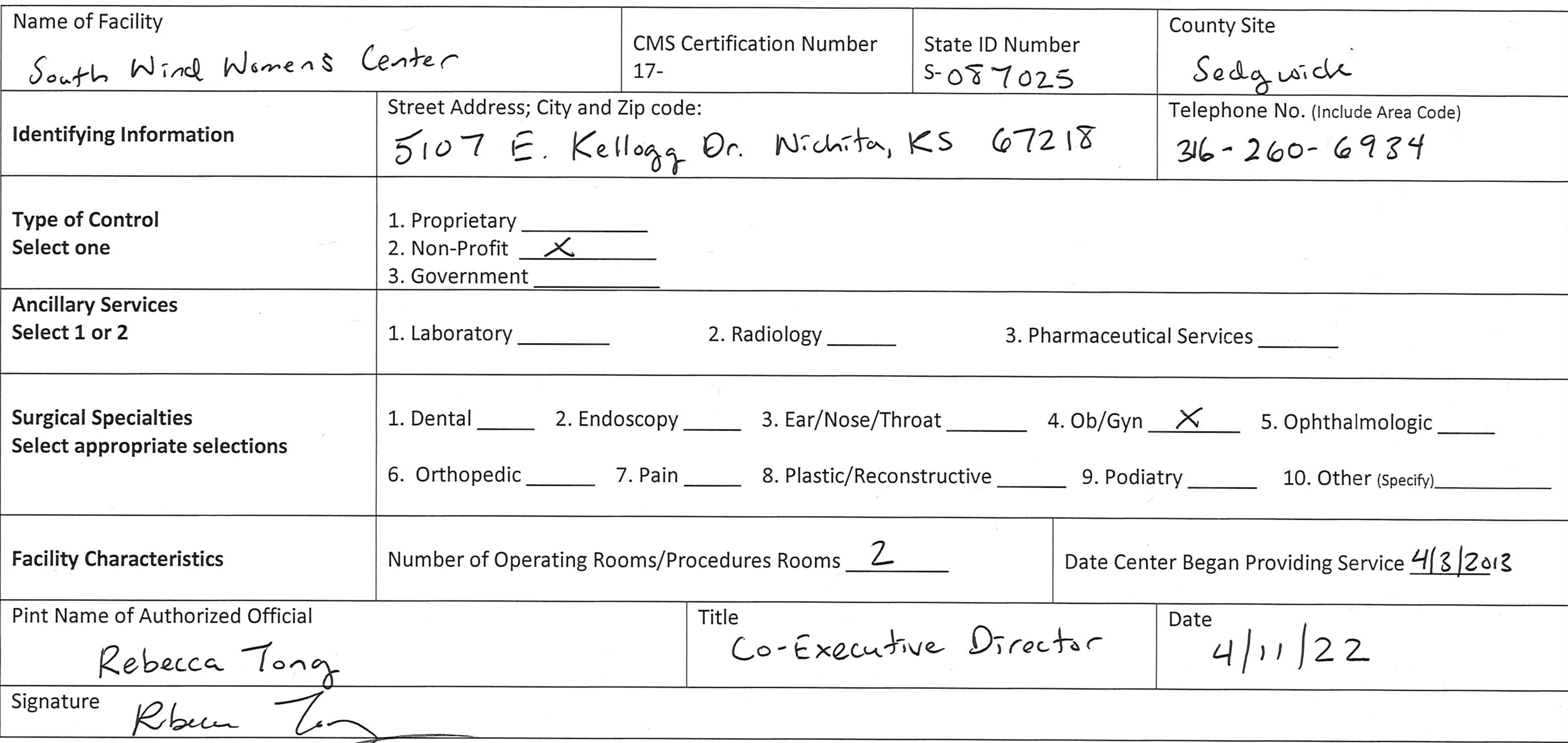
The following annual report information is valid for active and delinquent status entities only.

Tax Closing Month: 12

The Last Annual Report on File: 12/2020

Next Annual Report Due: 04/15/2022

Forfeiture Date: 07/15/2022



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 Womens Center	CMS Certification Number 17-	State ID Number S-087025	County Site Sedgwick
Identifying Information	Street Address; City and Zip code: 5107 E. Kellogg Dr. Wichita, KS 67218		Telephone No. (Include Area Code) 316-260-6934
Type of Control **Select one**	1. Proprietary ____ 2. Non-Profit X 3. Government ____		
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 4/3/2013
Pint Name of Authorized Official Rebecca Tong	Title Co-Executive Director		Date 4/11/22
Signature Rebecca Tong			

HOSPITAL PROFESSIONAL LIABILITY PROGRAM

Declarations-Claims Made

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

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

Policy Number: KSP0024050

Renews: 08/15/2022

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):
Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 60606

Item 2. Policy Period From 08/15/2021 to 08/15/2022
12:01 A.M. standard time at the address of the Named Insured as stated 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 OF LIABILITY		ADVANCE PREMIUMS
Hospital Professional Liability Insurance	Retroactive Date: 08/15/2014	$ 200,000	each claim	$ 6,000.00
		$ 600,000	annual aggregate	
		$	deductible	
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability	$	each occurrence	$
	(II) Personal Injury/Advertising 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

Countersigned by [signature]
Authorized Representative

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

Kansas
Department of Health
and Environment

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

July 25,

Health Facilities Program
MAY 04 2023
Acute & Continuing Care

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 ☐ Critical Access Hospital ☒ Ambulatory Surgery Center

B. ***Name of Medical Care Facility:*** South Wind Women's Center, LLC

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 Phone: 316-260-6934

* 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 S087.025

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: Trust Women Foundation, Inc.

Physical Address: 5107 E. Kellogg

City/State Zip code

B. *Type of Entity:* ☐ Corporation for profit ☑ Corporation non-profit

☐ Limited Liability Company (LLC) ☐ Professional Associates (P.A.)

☐ Government/County ______ ☐ Other (Explain) ______

Print Name	Title	Ownership %	Address
Rebecca Tong	Co-Executive Director	0	5107 E. Kellogg Dr. Wichita, KS 67218
Schaunta James-Boyd	Co-Executive Director	0	5107 E. Kellogg Dr. Wichita, KS 67218
Alison Regan	Board President	0	5107 E Kellogg Dr. Wichita, KS 67218
Anthony Tenbrink	Treasuer	0	5107 E Kellogg Dr. Wichita, KS 67218
Jessica Hasan-Wells	Secretary	0	5107 E Kellogg Dr. Wichita, KS 67218

General Information:

A. ***(FOR HOSPITALS ONLY)*** Number of Beds: General beds ______ Observation beds _____

Swing beds _______ IPPS beds _______ LTC ______ Bassinets _______

B. Number of Active Medical Staff 13

C. ***Check the box that applies:***

☑ This applicant is licensed only
☐ This applicant is licensed, accredited
☐ This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization ______________________ and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates ________________________________

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

☐ Surgery department
☐ Obstetrical department
☐ Outpatient department
☐ Pediatric department
☐ Long Term Care Unit
☐ Intensive coronary care units
☐ Radiology
☐ Social Services
☐ Psychiatric Services
☐ Dialysis Services
☐ Physical Therapy
☐ Occupational Therapy
☐ Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate Yes, please submit copy a of the current CLIA Certificate of Registration.

(Initials) RT I 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.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

Rebecca Tong — Co-Executive Dir.
Print Name — Title

[Signature]
Signature

316-425-3215
Phone number

4/20/2023
Date

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 completed application & documentation** 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

Limited Liability Company Annual Report

1. LLC Name: SOUTH WIND WOMEN'S CENTER LLC
2. Business Entity ID No.: 6710966
3. Tax Closing Date: December 2022
4. State of Organization: KS
5. 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

Trust Women Foundation
Post Office Box 3222 | Wichita, Kansas 67201 | 316.425.3215 | www.trustwomen.org

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

CLIA ID NUMBER
17D2056639

EFFECTIVE DATE
11/12/2022

LABORATORY DIRECTOR
CHRISTINA M BOURNE M.D.

EXPIRATION DATE
11/11/2024

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.

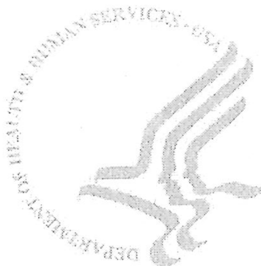
This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Monique Spruill
Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
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	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		



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, LLC		CMS Certification Number 17- D2056639	State ID Number S- 087025	County Site Sedgwick County
Identifying Information	Street Address; City and Zip code: 5107 E. Kellogg Dr. Wichita, KS 67218			Telephone No. (Include Area Code) 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 ____			
Surgical Specialties **Select appropriate selections**	1. Dental ☐ 2. Endoscopy ☐ 3. Ear/Nose/Throat ☐ 4. Ob/Gyn ☑ 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 04/11/2013	
Pint Name of Authorized Official Rebecca Tong		Title Co-Executive Director		Date 05/08/2023
Signature Rebecca Tong		Email Address rtong@itrustwomen.org		

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)

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

Policy Number: KSP0024050

Renews: 08/15/2023

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):

Item 2. Policy Period From 08/15/2022 to 08/15/2023
12:01 A.M. standard time at the address of the Named Insured as stated herein.

Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 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 policy having reference thereto.

COVERAGE PARTS	COVERAGES	LIMITS OF LIABILITY *		ADVANCE PREMIUMS
Professional Liability Insurance	Retroactive Date: 08/15/2014	$ 500,000	each claim	$ 6,000.00
		$ 1,500,000	annual aggregate	
		$	deductible	

*Notwithstanding the Limits of Liability stated above, 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.

COVERAGE PARTS	COVERAGES	LIMITS OF LIABILITY *		ADVANCE PREMIUMS
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability	$	each occurrence	$
	(II) Personal Injury/Advertising 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 01/22), 604 (ED 01/22)

Total Deposit Premium $ 6,000.00

Countersigned by
Authorized Representative

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 08/15/2022 12:01 a.m. TO 08/15/2023 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.

FOR HCSF USE ONLY

SECTION I – Health Care Provider Identification and Residency

Health Care Provider's Name: South Wind 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 provider

Health Care Provider's 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 Provider's Email Address:

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

☒ $500,000/$1,500,000

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.*

SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information

					For Fund Classes 1 to 14	For Fund Classes 15 to 24	
HCSF Rate Classification Number	Provider's License Number	Fund Compliance Year	Basic Coverage Premium Amount	HCSF Class Group Number	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment
	S087025	1	$ 6,000.00	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 below under "extraordinary circumstances"). The part-time factor used was ____ %.
- ☐ 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 Company Name:

Name of Agent or Other Company Representative: Sara Patry

Policy Number: KSP0024050

Agent or Company Rep. Email Address: SPATRY@KAMMCO.COM

Coverage Effective Date: 08/15/2022

Agent or Company Rep. Phone Number: (785) 232-2224

Coverage Expiration Date: 08/15/2023

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

Kansas
Ad Astra Per Aspera
Department of Health and Environment

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

Janet Stanek, Secretary

Laura Kelly, Governor

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

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

Department of Health
and Environment

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

July 25,

Health Facilities Program
MAY 04 2023
Acute & Continuing Care

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, LLC

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 Phone: 316-260-6934

* 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 SD87·025

Renewal Date 7.25.2023 Reviewed By M Cranister 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: Trust Women Foundation, Inc.

Physical Address: 5107 E. Kellogg

City/State Zip code

B. *Type of Entity:* ☐ Corporation for profit ☑ Corporation non-profit

☐ Limited Liability Company (LLC) ☐ Professional Associates (P.A.)

☐ Government/County __________ ☐ Other (Explain) __________

Print Name	Title	Ownership %	Address
Rebecca Tong	Co-Executive Director	0	5107 E. Kellogg Dr. Wichita, KS 67218
Schaunta James-Boyd	Co-Executive Director	0	5107 E. Kellogg Dr. Wichita, KS 67218
Alison Regan	Board President	0	5107 E Kellogg Dr. Wichita, KS 67218
Anthony Tenbrink	Treasuer	0	5107 E Kellogg Dr. Wichita, KS 67218
Jessica Hasan-Wells	Secretary	0	5107 E Kellogg Dr. Wichita, KS 67218

General Information:

A. ***(FOR HOSPITALS ONLY)*** Number of Beds: General beds ______ Observation beds _____

Swing beds _______ IPPS beds _______ LTC ______ Bassinets _______

B. Number of Active Medical Staff 13

C. ***Check the box that applies:***

- ☑ This applicant is licensed only
- ☐ This applicant is licensed, accredited
- ☐ This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization ______________________ and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates ________________________________

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

- ☐ Surgery department
- ☐ Obstetrical department
- ☐ Outpatient department
- ☐ Pediatric department
- ☐ Long Term Care Unit
- ☐ Intensive coronary care units
- ☐ Radiology
- ☐ Social Services
- ☐ Psychiatric Services
- ☐ Dialysis Services
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate Yes, please submit copy a of the current CLIA Certificate of Registration.

(Initials) RT I 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.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

Rebecca Tong Co-Executive Dir. — Print Name / Title

[signature] — Signature

316-425-3215 — Phone number

4/20/2023 — Date

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 completed application & documentation** 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

Limited Liability Company Annual Report

1. LLC Name: SOUTH WIND WOMEN'S CENTER LLC
2. Business Entity ID No.: 6710966
3. Tax Closing Date: December 2022
4. State of Organization: KS
5. 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

CLIA ID NUMBER

17D2056639

EFFECTIVE DATE

11/12/2022

LABORATORY DIRECTOR

CHRISTINA M BOURNE M.D.

EXPIRATION DATE

11/11/2024

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.

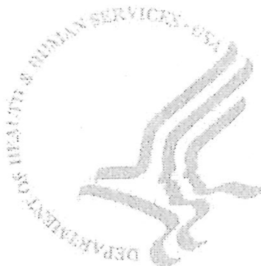
This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Monique Spruill
Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
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	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		



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.

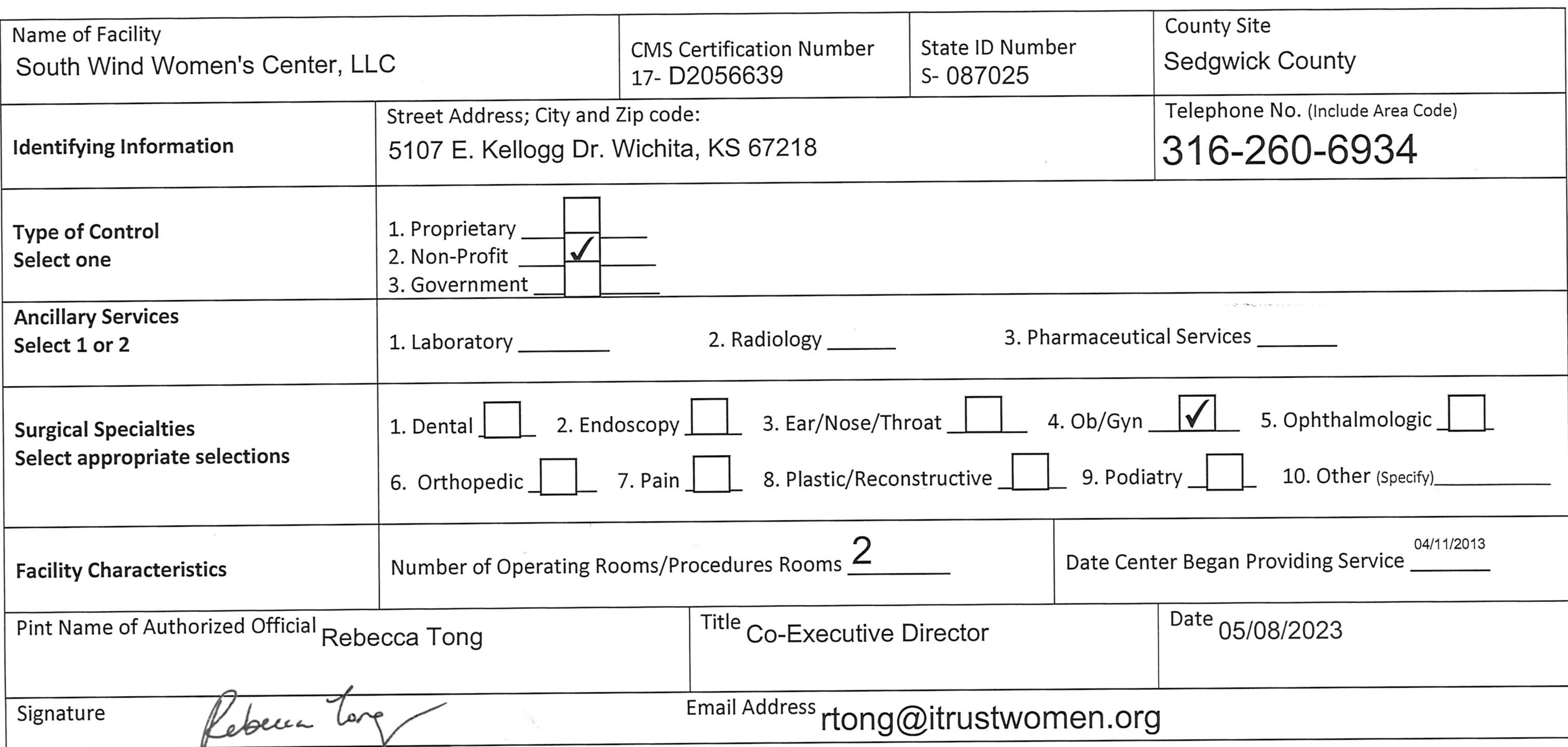
Ambulatory Surgery Center Updated Information

(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, LLC	CMS Certification Number 17- D2056639	State ID Number S- 087025	County Site Sedgwick County
Identifying Information	Street Address; City and Zip code: 5107 E. Kellogg Dr. Wichita, KS 67218		Telephone No. (Include Area Code) 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 ____
Surgical Specialties **Select appropriate selections**	1. Dental ☐ 2. Endoscopy ☐ 3. Ear/Nose/Throat ☐ 4. Ob/Gyn ☑ 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 04/11/2013
Pint Name of Authorized Official Rebecca Tong	Title Co-Executive Director		Date 05/08/2023
Signature Rebecca Tong	Email Address rtong@itrustwomen.org		

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)

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

Policy Number: KSP0024050

Renews: 08/15/2023

The Named Insured is:
General (Acute Care) Hospital ☐
Pediatric Hospital ☐
Psychiatric Hospital ☐
Teaching and/or Research ☐
Other (Specify):

Item 2. Policy Period From 08/15/2022 to 08/15/2023
12:01 A.M. standard time at the address of the Named Insured as stated herein.

Agent Name & Address:
USI Midwest
222 S Riverside Plaza
Chicago, IL 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 policy having reference thereto.

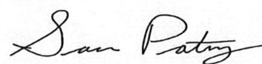
COVERAGE PARTS	COVERAGES	LIMITS OF LIABILITY *		ADVANCE PREMIUMS
Professional Liability Insurance	Retroactive Date: 08/15/2014	$ 500,000	each claim	$ 6,000.00
		$ 1,500,000	annual aggregate	
		$	deductible	

*Notwithstanding the Limits of Liability stated above, 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.

COVERAGE PARTS	COVERAGES	LIMITS OF LIABILITY *		ADVANCE PREMIUMS
Commercial General Liability Insurance	(I) Bodily Injury or Property Damage Liability	$	each occurrence	$
	(II) Personal Injury/Advertising 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 01/22), 604 (ED 01/22)

Total Deposit Premium $ 6,000.00

Countersigned by 

Authorized Representative

603 (ED 01/22)

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 08/15/2022 12:01 a.m. TO 08/15/2023 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.

FOR HCSF USE ONLY

SECTION I – Health Care Provider Identification and Residency

Health Care Provider's Name: South Wind 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 provider

Health Care Provider's 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 Provider's Email Address:

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

☒ $500,000/$1,500,000

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.*

SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information

HCSF Rate Classification Number	Provider's License Number	Fund Compliance Year	Basic Coverage Premium Amount	HCSF Class Group Number	For Fund Classes 1 to 14: HCSF Surcharge Payment From Rate Tables	For Fund Classes 15 to 24: HCSF Surcharge Percent	For Fund Classes 15 to 24: HCSF % Based Surcharge Payment
	S087025	1	$ 6,000.00	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 below under "extraordinary circumstances"). The part-time factor used was %.

☐ 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 Company Name:

Name of Agent or Other Company Representative:	Sara Patry	Policy Number:	KSP0024050
Agent or Company Rep. Email Address:	SPATRY@KAMMCO.COM	Coverage Effective Date:	08/15/2022
Agent or Company Rep. Phone Number:	(785) 232-2224	Coverage Expiration Date:	08/15/2023

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

Kansas
Department of Health
and Environment

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

Janet Stanek, Secretary

Laura Kelly, Governor

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