STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

RECEIVED
JUL 30 2010
HEALTH STANDARDS

Department of HEALTH and HOSPITALS

ABORTION FACILITIES
LICENSE APPLICATION

___ INITIAL ✓ RENEWAL ___ OTHER (Specify) _____

LICENSE NUMBER 07 EXPIRATION DATE 8/31/2010

TOTAL FEE AMOUNT INCLUDED $ 600.00 CHECK / MONEY ORDER # 7635

☐ check if any change has occurred since last application

STATE ID# AB0004642

I. FACILITY (DBA) NAME Delta Clinic of Baton Rouge, INC.

GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER 225 923-3242 FAX NUMBER 225 924-4465

II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY / STATE / ZIP Same As Above

III. ADMINISTRATOR Sylvia Cochran MEDICAL DIRECTOR: Dr. Mary F. Gardner

REGISTERED NURSE: _____ PHYSICIAN ASSISTANT: _____ LPN: Natasha Seymour

IV. TYPE OF OWNERSHIP:

NON- PROFIT	FOR - PROFIT
☐ INDIVIDUAL / SOLE PROPRIETOR	☐ INDIVIDUAL / SOLE PROPRIETOR
☐ CORPORATION	☒ CORPORATION
☐ PARTNERSHIP	☐ PARTNERSHIP
☐ RELIGIOUS AFFILIATION	☐ GROUP PRACTICE
☐ UNINCORPORATED ASSOCIATION	☐ OTHER (Specify) _____
☐ OTHER (Specify): _____	

V. ENTITY / CORPORATION NAME Delta Clinic of Baton Rouge, Inc

MAILING ADDRESS (IF DIFFERENT) 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER 225 923-3242 FAX NUMBER 225 924-4465

VII. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER NAME	ADDRESS	TELEPHONE #
Pansy Myrie	1704 N. Park Drive #310	161-62-9745
	Wilmington, DE 19806	

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER
Leroy T. Brinkley	8402 Thomas Mill Rd Philadelphia, PA 19128	215 482-3764

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☑ YES ☐ NO
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.

NAME	ADDRESS	PROVIDER NUMBER
Pansy M. Myre	1704 N. Park Dr. # 310	Women's Health Care Ctr
	Wilmington, DE 19806	Lic #3

IX. Has there been a change of ownership or control within the last year? ☐ YES ☒ NO
If yes, give date. _____

X. PROGRAM OPERATIONAL INFORMATION:

DAYS OF OPERATION Monday - Friday HOURS OF OPERATION 9Am - 5pm

Is this a change since last application? ☐ YES ☒ NO

ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Betty Harrell-Myles
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

BMyles
AUTHORIZED REPRESENTATIVE SIGNATURE

7/23/2010
DATE

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

ABORTION FACILITIES JUL 29 2009
LICENSE APPLICATION

HEALTH STANDARDS

___ *INITIAL* ✓ *RENEWAL* ___ *OTHER (Specify)*

LICENSE NUMBER 07 *EXPIRATION DATE* 8/31/2009

TOTAL FEE AMOUNT INCLUDED $600- *CHECK / MONEY ORDER #* 7774

☐ check if any change has occurred since last application

STATE ID# ~~AB~~ LA 000 4642

I. *FACILITY (DBA) NAME* Delta Clinic of Baton Rouge, Inc

GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER 225 923-3242 *FAX NUMBER* 225 924-4465

II. *MAILING ADDRESS (IF DIFFERENT FROM ABOVE)* Same as above

CITY / STATE / ZIP

III. ADMINISTRATOR Sylvia Cochran MEDICAL DIRECTOR: Dr. Mary F. Gardner

REGISTERED NURSE: None PHYSICIAN ASSISTANT: None LPN: Horesal Williams

IV. TYPE OF OWNERSHIP:

NON- PROFIT	FOR - PROFIT
☐ *INDIVIDUAL / SOLE PROPRIETOR*	☐ *INDIVIDUAL / SOLE PROPRIETOR*
☐ *CORPORATION*	☒ *CORPORATION*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*
☐ *RELIGIOUS AFFILIATION*	☐ *GROUP PRACTICE*
☐ *UNINCORPORATED ASSOCIATION*	☐ *OTHER (Specify)* _____
☐ *OTHER (Specify):* _____	

V. *ENTITY / CORPORATION NAME* Delta Clinic of Baton Rouge, Inc.

MAILING ADDRESS (IF DIFFERENT) 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, La 70806

TELEPHONE NUMBER 225 923-3242 *FAX NUMBER* 225 924-4465

VII. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER NAME	ADDRESS	*TELEPHONE #*
Pansy Myrie	1704 N. Park Drive, #310 Wilmington, DE 19806	161-62-9745

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING
HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER
Leroy T. Brinkley	8602 Thomas Mill Road Philadelphia, PA 19128	215-482-3764

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☒ YES ☐ NO
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.

NAME	ADDRESS	PROVIDER NUMBER
Pansy M. Myre	1704 N. Park Dr #310	Women's
	Wilmington, DE 19806	Health Care Ctr. INC. N.O. LA Lic#03

IX. Has there been a change of ownership or control within the last year? ☐ YES ☒ NO
If yes, give date. _____

X. PROGRAM OPERATIONAL INFORMATION:

DAYS OF OPERATION Mon - Fri HOURS OF OPERATION T, TH 730a - 5p M, W, F 9:00a - 5p

Is this a change since last application? ☐ YES ☒ NO

ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Betty Harrell-Myles
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

BMyles
AUTHORIZED REPRESENTATIVE SIGNATURE

7/16/2009
DATE

JUL 29 2009
HEALTH STANDARDS

HSS-AB-01 (12/08)

RECEIVED
AUG 6
HEALTH STANDARDS

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA

RECEIVED
AUG 6 2008
Department of HEALTH and HOSPITALS
HEALTH STANDARDS

AMBULATORY SURGICAL CENTER
LICENSE APPLICATION

___ INITIAL X RENEWAL ___ OTHER (Specify) _____

LICENSE NUMBER 07 EXPIRATION DATE 8/31/08

TOTAL FEE AMOUNT INCLUDED $600- CHECK / MONEY ORDER # _____

STATE ID# AS000 4642

☐ check if any change has occurred since last application

I. FACILITY (DBA) NAME Delta Clinic of Baton Rouge, Inc.

GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER 225 923-3242 FAX NUMBER 225 924-4465

II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY / STATE / ZIP Same as above

II. ADMINISTRATOR Sylvia A. Cochran DIRECTOR OF NURSING: Dr. Mary F Gardner

V. LOCATION: ☐ HOSPITAL BASED ☐ FREE STANDING

7. TYPE OF OWNERSHIP:

NON- PROFIT
- ☐ INDIVIDUAL / SOLE PROPRIETOR
- ☒ CORPORATION
- ☐ PARTNERSHIP
- ☐ RELIGIOUS AFFILIATION
- ☐ UNINCORPORATED ASSOCIATION
- ☐ OTHER (Specify): _____

FOR - PROFIT
- ☐ INDIVIDUAL / SOLE PROPRIETOR
- ☐ CORPORATION
- ☐ PARTNERSHIP
- ☐ GROUP PRACTICE
- ☐ OTHER (Specify) _____

GOVERNMENT
- ☐ FEDERAL
- ☐ STATE
- ☐ PARISH
- ☐ CITY / PARISH
- ☐ CITY
- ☐ HOSPITAL DISTRICT
- ☐ COMBINATION GOV-N-PROFIT
- ☐ OTHER Specify) _____

VI. ENTITY / CORPORATION NAME Delta Clinic of Baton Rouge, Inc.

MAILING ADDRESS (IF DIFFERENT) 756 Colonial Drive Ste B.

CITY / STATE / ZIP Baton Rouge LA 70806

TELEPHONE NUMBER (225) 923-3242 FAX NUMBER (225) 924-4465

VII. List name, address, and Telephone numbers for persons or group of persons, or the employer identification number (EIN) for organizations having direct or indirect ownership or a controlling interest (> 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER NAME	ADDRESS	EIN
Pansy Myrie	1704 N. Park Drive # 310 Wilmington, DE 19806	161-62-9745

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING
HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER
Leroy T. Brinkley	8602 Thomas Mill Road Philadelphia, PA 19128	215-482-3764

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☒ YES ☐ NO
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.

NAME	ADDRESS	PROVIDER NUMBER
Pansy M. Myre	1704 N. Park # 310 Wilmington, DE 19806	Women's Healthcare Center, INC. New Orleans, LA Lic # 3

IX. Has there been a change of ownership or control within the last year? ☐ YES ☒ NO
If yes, give date. _____

X. PROGRAM OPERATIONAL INFORMATION:

DAYS OF OPERATION Monday - Friday HOURS OF OPERATION 9 AM - 5pm

Is this a change since last application ? ☐ YES ☒ NO

ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Betty Harrell-Myles
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

BMyles
AUTHORIZED REPRESENTATIVE SIGNATURE

7/11/08
DATE

Please Send current Fire + Health Inspection Report.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

ABORTION FACILITIES
LICENSE APPLICATION

__ *INITIAL* ✓ *RENEWAL* __ *OTHER (Specify)* _____

LICENSE NUMBER 07 *EXPIRATION DATE* 8/31/07

TOTAL FEE AMOUNT INCLUDED $600 *CHECK / MONEY ORDER #* 5761

☐ check if any change has occurred since last application STATE ID# AB000 4642

I. *FACILITY (DBA) NAME* Delta Clinic of Baton Rouge, INC.

GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER (225) 923-3242 *FAX NUMBER* (225) 924-4465

II. *MAILING ADDRESS (IF DIFFERENT FROM ABOVE)* _____

CITY / STATE / ZIP Same

II. ADMINISTRATOR _____ MEDICAL DIRECTOR: _____

STERED NURSE: _____ PHYSICIAN ASSISTANT: _____ LPN: _____

V. TYPE OF OWNERSHIP:

NON- PROFIT	FOR - PROFIT
☐ *INDIVIDUAL / SOLE PROPRIETOR*	☐ *INDIVIDUAL / SOLE PROPRIETOR*
☐ *CORPORATION*	☒ *CORPORATION*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*
☐ *RELIGIOUS AFFILIATION*	☐ *GROUP PRACTICE*
☐ *UNINCORPORATED ASSOCIATION*	☐ *OTHER (Specify)* _____
☐ *OTHER (Specify):* _____	

. ENTITY / CORPORATION NAME Delta Clinic of Baton Rouge, INC.

AILING ADDRESS (IF DIFFERENT) Same as above

ITY / STATE / ZIP _____

ELEPHONE NUMBER (___) _____ *FAX NUMBER* (___) _____

I. List name, address, and Telephone numbers for persons or group of persons, or the employer identification number (EIN) for organizations having direct or direct ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business terest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether ch stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity TTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).

OWNER NAME	ADDRESS	EIN
Sansy Myrie	1704 N. Park Drive #310 Wilmington, DE 19806	161-62-9745

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING
HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER
Leroy T. Brinkley	8602 Thomas Mill Road Philadelphia, PA. 19128	(215) 482-3764

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☒ YES ☐ NO
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.

NAME	ADDRESS	PROVIDER NUMBER
Pansy M. Myre	1704 N. Park Drive #310 Wilmington, De 19806	Womens Health Care Center New Orleans, LA LIC #3

IX. Has there been a change of ownership or control within the last year? ☐ YES ☒ NO
If yes, give date. _____

X. PROGRAM OPERATIONAL INFORMATION:

DAYS OF OPERATION Monday - Friday HOURS OF OPERATION 9:00 AM - 5:00 PM

Is this a change since last application ? ☑ YES ☐ NO

ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Betty Harrell-Myles
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

AUTHORIZED REPRESENTATIVE SIGNATURE

7/25/2007
DATE

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

ABORTION FACILITIES
LICENSE APPLICATION

___ INITIAL ✓ RENEWAL ___ OTHER (Specify) _____

LICENSE NUMBER 07 EXPIRATION DATE 8-31-06

TOTAL FEE AMOUNT INCLUDED $600 CHECK / MONEY ORDER # 4782

☐ check if any change has occurred since last application

I. FACILITY (DBA) NAME Delta Clinic of Baton Rouge, Inc STATE ID# AB000 4642

GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER 225 923-3242 FAX NUMBER 225 924-4465

II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY / STATE / ZIP Same

I. ADMINISTRATOR Sylvia Ann Cochran MEDICAL DIRECTOR Dr. Mary Frances Gardner

EGISTERED NURSE: _____ PHYSICIAN ASSISTANT: _____ LPN: _____

YPE OF OWNERSHIP:

NON- PROFIT	FOR - PROFIT
☐ INDIVIDUAL / SOLE PROPRIETOR	☐ INDIVIDUAL / SOLE PROPRIETOR
☐ CORPORATION	☒ CORPORATION
☐ PARTNERSHIP	☐ PARTNERSHIP
☐ RELIGIOUS AFFILIATION	☐ GROUP PRACTICE
☐ UNINCORPORATED ASSOCIATION	☐ OTHER (Specify) _____
☐ OTHER (Specify): _____	

. ENTITY / CORPORATION NAME Delta Clinic of Baton Rouge, Inc.

AILING ADDRESS (IF DIFFERENT) Same as above

TY / STATE / ZIP _____

LEPHONE NUMBER ( ) _____ FAX NUMBER ( ) _____

. List name, address, and Telephone numbers for persons or group of persons, or the employer identification number (EIN) for organizations having direct or irect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business rest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity TTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).

OWNER NAME	ADDRESS	EIN
M. Myrie	1704 N. Park Drive #310 Wilmington, DE 19806	161-62-9745

DEPARTMENT OF HEALTH AND HOSPITALS

HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER
Leroy T. Brinkley	8602 Thomas Mill Road 215 Philadelphia, Pa. 19128	482-3764

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☒ YES ☐ NO
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.

NAME	ADDRESS	PROVIDER NUMBER
Pansy M. Myrie	1704 N. Park Drive #310 Wilmington, De 19806	Women's Health Care Center New Orleans, LA Lic #3

IX. Has there been a change of ownership or control within the last year? ☐ YES ☒ NO
If yes, give date. _____

X. PROGRAM OPERATIONAL INFORMATION:

DAYS OF OPERATION Monday - Friday HOURS OF OPERATION 9:00 AM - 5:00 PM

Is this a change since last application ? ☐ YES ☐ NO

ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ...rship. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards ...tion in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and ...upportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the ...Department of Health and Hospitals.

Sylvia Ann Cochran
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

Sylvia A. Cochran
AUTHORIZED REPRESENTATIVE SIGNATURE

7/27/06
DATE

Please Send current Fire + Health Inspection Report.

S-AB-01 (7/03)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

ABORTION FACILITIES
LICENSE APPLICATION

___ *INITIAL* ✓ *RENEWAL* ___ *OTHER* (Specify) _____

LICENSE NUMBER 07 *EXPIRATION DATE* 8-31-05

TOTAL FEE AMOUNT INCLUDED $200.00 *CHECK / MONEY ORDER #* 3389

☐ check if any change has occurred since last application

STATE ID# ~~AB~~000 4642 (130)

I. *FACILITY (DBA) NAME* Delta Clinic of Baton Rouge, Inc.

GEOGRAPHICAL ADDRESS 756 Colonial Drive, Suite B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER (225) 923-3242 *FAX NUMBER* (225) 924-4465

II. *MAILING ADDRESS (IF DIFFERENT FROM ABOVE)* _____

CITY / STATE / ZIP _____

ADMINISTRATOR Sylvia A. Cochran MEDICAL DIRECTOR: Mary Frances Gardner, MD

REGISTERED NURSE: _____ PHYSICIAN ASSISTANT: _____ LPN: _____

TYPE OF OWNERSHIP:

NON- PROFIT	FOR - PROFIT
☐ *INDIVIDUAL / SOLE PROPRIETOR*	☐ *INDIVIDUAL / SOLE PROPRIETOR*
☑ *CORPORATION*	☑ *CORPORATION*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*
☐ *RELIGIOUS AFFILIATION*	☐ *GROUP PRACTICE*
☐ *UNINCORPORATED ASSOCIATION*	☐ *OTHER (Specify)* _____
☐ *OTHER (Specify):* _____	

RECEIVED
JUL 22 2005
HEALTH STANDARDS

ENTITY / CORPORATION NAME Same As Above

MAILING ADDRESS (IF DIFFERENT) _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (___) _____ *FAX NUMBER* (___) _____

. List name, address, and Telephone numbers for persons or group of persons, or the employer identification number (EIN) for organizations having direct or irect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business rest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether ock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *CH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER NAME	ADDRESS	EIN
Leroy Thomas Brinkley	2509 Baynard Blvd	180-30-1304
	Wilmington, DE 19802	302-888-1102

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING
HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☒ YES ☐ NO
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.

NAME	ADDRESS	PROVIDER NUMBER
Leroy Thomas Brinkley	2809 Baynard Blvd - Wilmington, DE	19802
Womens Health Care Center	2701 General Pershing - New Orleans, LA	70115 03

IX. Has there been a change of ownership or control within the last year? ☐ YES ☒ NO
If yes, give date. _____

X. PROGRAM OPERATIONAL INFORMATION:

DAYS OF OPERATION Monday - Saturday HOURS OF OPERATION 9-5 telephone
Surgical days and hours vary from week to week

1. Is a change since last application ? ☐ YES ☒ NO

ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Sylvia Ann Cochran
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

Sylvia A Cochran
AUTHORIZED REPRESENTATIVE SIGNATURE

7/15/05
DATE

HSS-AB-01 (7/03)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

ABORTION FACILITIES
LICENSE APPLICATION

___ INITIAL ___ RENEWAL X OTHER (Specify) Re Application

LICENSE NUMBER _____ EXPIRATION DATE _____

TOTAL FEE AMOUNT INCLUDED 600.00 CHECK / MONEY ORDER # 2648

☐ check if any change has occurred since last application STATE ID# AB000 ____

I. FACILITY (DBA) NAME Delta Clinic of Baton Rouge, Inc

GEOGRAPHICAL ADDRESS 756 Colonial Drive Ste B

CITY / STATE / ZIP Baton Rouge, LA 70806

TELEPHONE NUMBER 225 923-3242 FAX NUMBER 225 924-4465

II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY / STATE / ZIP _____

II. ADMINISTRATOR Sylvia Ann Cochran MEDICAL DIRECTOR: Mary Frances Gardner MD

EGISTERED NURSE: _____ PHYSICIAN ASSISTANT: _____ LPN: _____

V. TYPE OF OWNERSHIP:

NON- PROFIT	FOR - PROFIT
☐ INDIVIDUAL / SOLE PROPRIETOR	☐ INDIVIDUAL / SOLE PROPRIETOR
☐ CORPORATION	☒ CORPORATION
☐ PARTNERSHIP	☐ PARTNERSHIP
☐ RELIGIOUS AFFILIATION	☐ GROUP PRACTICE
☐ UNINCORPORATED ASSOCIATION	☐ OTHER (Specify) _____
☐ OTHER (Specify): _____	

RECEIVED
JUL 20 2004
HEALTH STANDARDS

V. ENTITY / CORPORATION NAME Delta Clinic of Baton Rouge, Inc

MAILING ADDRESS (IF DIFFERENT) _____

CITY / STATE / ZIP Same as above

TELEPHONE NUMBER (___) _____ FAX NUMBER (___) _____

VI. List name, address, and Telephone numbers for persons or group of persons, or the employer identification number (EIN) for organizations having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity (ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).

OWNER NAME	ADDRESS	EIN
Leroy T. Brinkley	2809 Baynard Blvd	180-30-1304
	Wilmington, De 19802 302	888-1102

TE OF LOUISIANA
'ARTMENT OF HEALTH AND HOSPITALS

BUREAU OF HEALTH SERVICES FINANCING
HEALTH STANDARDS SECTION

ABORTION FACILITIES LICENSE APPLICATION

II. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER

III. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ YES ☐ NO
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.

NAME	ADDRESS	PROVIDER NUMBER
Leroy T. Brinkley	2809 Baynard Blvd-Wilm DE	03
Women's Health Care Center	2701 General Pershing Street New Orleans, LA 70115	

Has there been a change of ownership or control within the last year? ☐ YES ☒ NO
If yes, give date. _____

PROGRAM OPERATIONAL INFORMATION:

YS OF OPERATION Monday - Saturday HOURS OF OPERATION 9-5 Telephones
his a change since last application? ☐ YES ☐ NO Surgical days and hours vary from week to week

TESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of nership. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards ction in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and pportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the partment of Health and Hospitals.

Sylvia Ann Cochran
UTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

Sylvia Ann Cochran
AUTHORIZED REPRESENTATIVE SIGNATURE

7/14/04
DATE

S-AB-01 (7/03)

State of Louisiana

Department of Health and Hospitals

LICENSE

07

This is to certify that Delta Clinic of Baton Rouge, Inc.
is hereby duly licensed to operate Delta Clinic of Baton Rouge, Inc. at
756 Colonial Drive Suite B
Baton Rouge, LA 70806
with a licensed capacity of N/A

This license shall expire on 08/31/2011, but may be revoked or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

08/31/2010
Date of Issue

Director

State of Louisiana

Department of Health and Hospitals

LICENSE

07

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is hereby duly licensed to operate Delta Clinic of Baton Rouge, Inc. at
756 Colonial Drive Suite B
Baton Rouge, LA 70806
with a licensed capacity of N/A

This license shall expire on 08/31/2010, but may be revoked or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

08/21/2009
Date of Issue

Director

State of Louisiana

Department of Health and Hospitals

LICENSE

07

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is hereby duly licensed to operate Delta Clinic of Baton Rouge, Inc. at
756 Colonial Drive Suite B
Baton Rouge, LA 70806
with a licensed capacity of N/A

This license shall expire on 08/31/2009, but may be revoked or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

08/22/2008
Date of Issue

Director

State of Louisiana

Department of Health and Hospitals

LICENSE

07

This is to certify that Delta Clinic of Baton Rouge, Inc.
is hereby duly licensed to operate Delta Clinic of Baton Rouge, Inc. at
756 Colonial Drive Suite B
Baton Rouge, LA 70806
with a licensed capacity of N/A

This license shall expire on 08/31/2008, but may be revoked or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

08/20/2007
Date of Issue

Erica C. Robalain
Director

State of Louisiana

Department of Health and Hospitals

LICENSE

07

This is to certify that Delta Clinic of Baton Rouge, Inc.
is hereby duly licensed to operate Delta Clinic of Baton Rouge, Inc. at
756 Colonial Drive Suite B
Baton Rouge, LA 70806
with a licensed capacity of N/A

This license shall expire on 08/31/2007, but may be revoked or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

08/20/2006
Date of Issue

Erica C. Kabalais
Director

State of Louisiana

Department of Health and Hospitals

LICENSE

07

This is to certify that Delta Clinic of Baton Rouge, Inc.
is hereby duly licensed to operate Delta Clinic of Baton Rouge, Inc. at
756 Colonial Drive Suite B
Baton Rouge, LA 70806
with a licensed capacity of N/A

This license shall expire on 08/31/2006, but may be revoked or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

08/22/2005
Date of Issue

Lisa M. Dixon, M.D.
Director

State of Louisiana

Department of Health and Hospitals

LICENSE

07

This is to certify that Delta Clinic of Baton Rouge, Inc.
is hereby duly licensed to operate ABORTION CLINIC at
756 Colonial Drive
Baton Rouge, LA 70806
with a licensed capacity of N/A

This license shall expire on 08/31/2005, but may be revoked or suspended at any time as provided in the Licensing Law or Minimum Standards pertaining thereto. This license is not transferable and must be renewed annually.

09/28/2004
Date of Issue

Lisa M. Deaton, RN
Director

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

February 1, 2010

Certified Mail Return Receipt Requested # 7007 2680 0000 8113 6342

Sylvia Cochran, Administrator
Delta Clinic Of Baton Rouge, Inc
756 Colonial Drive
Baton Rouge, LA 70806

Re: Survey 12/07/2009 Plan of Correction

Dear Ms. Cochran:

This letter acknowledges receipt of your facility's plan of correction for deficiencies cited during the licensing survey of December 7, 2009. The Plan of Correction (PoC) submitted by your facility is not acceptable and will require the following revisions before it can be considered acceptable by this Department:

Tag S4405 -The PoC for items #1 and #2 indicates that the facility will collect data at different intervals during the year, but corrective action will only be addressed annually when submitted to the governing body. Additionally, item # 1 has an effective date of 12/12/09, but the completion date listed is 12/08/09.

Tag S4409 & S4411 - The PoC for these tags indicates that the office manager will be responsible for implementing the PoC for a period of one year. How will the facility ensure that the PoC continues to be followed and ensure that compliance is sustained?

Tag S4415 - The PoC for item #1 indicates that "Delta Clinic acknowledges that information concerning its patient records managed to reach the Public by way of the Louisiana Department of Health and Hospitals." This is an incorrect statement. The Louisiana Department of Health and Hospitals **did not** release or make public any Delta Clinic's patient records in any manner. Please delete this statement from the PoC.

Tag S4419 - The PoC for item #2 indicates that the facility will mix a solution of Cavacide and water. However, it is not clear that the solution mixture is compliant with the manufacturer's suggested guidelines. Please submit a copy of the manufacturer's guidelines and documentation that the solution mixture to be used is compliant with the requirements.

Tag S4421 - The PoC for item #3 indicates that the physician's standing orders are dated and signed by the physicians as being approved, but the PoC does not address how the facility will ensure the physician's standing orders will be timed, dated and signed by the physician and made specific for each patient and entered into each patient's chart. An approval as to whether or not the physician's standing orders submitted with this PoC were acceptable was not made. This tag was cited for the facility's failure to ensure that the physician's standing orders were timed, dated, and signed by the physician.

Please address the above mentioned item(s) by placing the amended plan of correction on the enclosed original statement of deficiency report form. Should you need additional space, you may use additional blank pages referencing each Tag number followed by the revised plan of correction. **The original deficiency report form and the amended plan of correction must be returned to this office no later than 24 hours after receipt.** Please advise this office if you will not be able to meet this deadline. I have also enclosed the "5 components" for an acceptable Plan of Correction which must be included in the revised plan of correction.

If you have any questions, please contact me at 225-342-6096.

Sincerely,

Dora Kane, R.N.
Non-Long Term Care Supervisor

Enclosure

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals

Bureau of Health Services Financing

IMPORTANT NOTICE- PLEASE READ CAREFULLY

DATE: 02/08/2011

TO: ADMINISTRATOR Delta Clinic Of Baton Rouge, Inc

FROM: HEALTH STANDARDS SECTION

RE: ANNUAL LICENSING SURVEY RESULTS

On February 3, 2011, a survey was conducted at your facility by the Department of Health and Hospitals, Health Standards Section, to determine if your facility was in compliance with licensing standards established by the State of Louisiana. This survey found deficiencies in your facility whereby corrections are required to assure compliance with licensing standards.

Enclosed for your completion and prompt response is the STATE FORM (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (PoC)). A PoC for the deficiencies must be submitted within 10 working days after your receipt of the STATE FORM. In the column "Completion Date," enter a projected date of correction. An explicit date must be shown. This date may not exceed 60 days from the completion of the survey. **Please refer to the enclosed memorandum, Required Components for the Plan of Correction, for guidance in developing your PoC.** Failure to submit an **acceptable** PoC by the date indicated **below** may result in the imposition of specified remedies. The STATE FORM must be **signed and dated by the administrator** or other authorized official as indicated. The **SIGNIFICANT FINDINGS** form, if enclosed, does not require a PoC, but the facility is expected to sign, date, and return the form.

You have one opportunity to question citations of deficient practice through an Informal Dispute Resolution process. To be given such an opportunity you must send your written request, specifying the deficient practice(s) that you are disputing and why you are questioning these, to: DHH/Health Standards Section, Attention IDR Program Manager, P.O. Box 3767, Baton Rouge, LA 70821-3767. The request must be made within 10 days of receipt of your STATE FORM. Again, this is an informal dispute resolution and it is not necessary for your attorney to be present, however, if you wish for your attorney to be included in the informal dispute resolution, please advise this office. Please refer to the enclosed memorandum, **Informal Dispute Resolution Process**, for further information.

Please provide this PoC by February 21, 2011. **Mail the completed original and properly signed/dated PoC to: Health Standards Section, Attention Program Manager, P.O. Box 3767, Baton Rouge, Louisiana 70821-3767.**

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals

Bureau of Health Services Financing

02/22/2011

Ms. Sylvia A. Cochran, Administrator
Delta Clinic Of Baton Rouge, Inc
756 Colonial Drive
Baton Rouge, LA 70806

Dear Ms. Cochran:

This letter acknowledges receipt of your facility's plan of correction for deficiencies cited during the licensing survey of February 3, 2011. The plan of correction submitted by your facility is not acceptable and will require the following revisions before it can be considered acceptable by this Department:

1. Tags S4405 and S4415: The plan of correction must specify that prior to an abortion procedure being performed the M.D. shall ensure that proper consents and reporting requirments have been met.

Please address the above mentioned item(s) by placing the amended plan of correction on a seperate sheet of paper. Please identify the tag numbers for each revision made to the revised Plan of Correction. Please fax the revisions no later than 24 hours after receipt to 225-342-0157. If you have any questions, please contact me at 225-342-2205.

Sincerely,

Christopher Vincent, RN, BSN
Medical Certification Program Manager
Abortion Facilities, ASCs, and Hospitals

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

January 20, 2010

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
 # 7007 2680 0000 8114 3043

Attn: Ms. Sylvia A. Cochran
Delta Clinic of Baton Rouge, Inc.
756 Colonial Drive
Baton Rouge, LA 70806

RE: Delta Clinic Of Baton Rouge, Inc
ID:N/A Medicaid ID:N/A State ID: BO0004642

Dear Ms. Cochran:

On 12/07/2009, a licensure survey and a survey on complaint #9AB28180 were conducted at the above referenced facility. At that time it was determined that the facility was out of compliance with the federal and/or state rules for hospitals. Specifically, the facility had deficient practices, including Immediate Jeopardy, in the following areas:

St - S - 4409 - - Personnel
St - S - 4419 - - Infection Control
St - S - 4421 - - Pharmaceutical Services

This office has determined that your facility's failure to comply with these rules constitutes separate **Class "B" violations** pursuant to a final rule published by this Department in July of 2000, in that the above referenced facility's actions or inactions created the substantial probability that serious harm or death would result to a patient(s) if the situation was not corrected. **As a result of these infractions, we are assessing this facility a Civil Fine of $1,400.00 for the violations under Tag S-4409, a Civil Fine of $800.00 for the violations under Tag S-4419, and a Civil Fine of $800.00 for the violations under Tag S-4421, for these Class "B" violations, as referenced in this letter.**

Therefore, the total amount of the Civil Fines assessed against this facility for these separate Class "B" violations, as referenced in this letter, is $3,000.00.

Further details of these violations are included in the 12/07/2009 survey statement of deficiencies, "State Form" (previously received by this facility) which are

incorporated by reference herein.

You may request an **Informal Reconsideration** of this decision to impose a civil fine. The request for Informal Reconsideration must be in writing and must be forwarded to the following address:

IDR Program Manager
BHSF, Health Standards Section
P. O. Box 3767
Baton Rouge, LA 70821-3767

Your request for Informal Reconsideration must be received by this office within ten (10) days from receipt of this notice letter and must include any documentation that you think demonstrates this determination was made in error. If a timely request for the Informal Reconsideration is received by this office, an Informal Reconsideration will be scheduled and you will be notified of the time and place. The reconsideration decision shall be based upon all documentation and oral testimony furnished by the provider to the department at the time of the Informal Reconsideration.

You also have the right to an **Administrative Appeal** regarding this decision. If you desire to appeal the proposed civil fine, you must file a written request within thirty (30) days after receipt of this notice letter. Your request for an Administrative Appeal must be forwarded to the following:

Department of Health and Hospitals
Bureau of Appeals
Post Office Box 4183
Baton Rouge, LA 70821-4183

The Bureau of Appeals will require a party requesting an appeal to (1) post an appeal bond with the Bureau of Appeals as provided in La. R.S. 40:2199(D), or (2) file a devolutive appeal wherein the facility pays the civil fine pending the outcome of the appeal.

The Department's decision to impose the civil fine becomes final and no administrative or judicial relief may be obtained if you fail to timely request an Informal Reconsideration and/or Administrative Appeal.

Please note that the request for an Informal Reconsideration does not constitute a request for an Administrative Appeal, nor does it extend the time limit for requesting an Administrative Appeal.

Also, please note that if you do not request an Administrative Reconsideration or an Administrative Appeal, this letter constitutes notice of this Department's final decision to impose a sanction. Once the delays for filing for an Administrative Reconsideration and/or Administrative Appeal have run, the decision to impose this Civil Fine becomes final and you must remit your payment within ten (10) days to:

La. Department of Health and Hospitals
ATTN: James Taylor, Sanction Desk
Post Office Box 3767
Baton Rouge, LA 70821-3767

Upon remittance, clearly indicate that the check is for payment of a civil monetary penalty.

If you have any questions regarding this letter, please contact James H. Taylor, III at (225) 342-5457.

Sincerely,
BHSF,HealthStandards Section

BY: Erin Rabalais, RN
Erin Rabalais, RN
Section Chief

ER\JHT

cc: File Copy
Hospital Program Desk
Ivory Trent, Bureau of Appeals
Mike Chapman, Financial Management

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

February 25, 2011

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
 # 7007 2680 0000 8269 1413

Delta Clinic of Baton Rouge, Inc.
Attn: Ms. Sylvia A. Cochran, Administrator
756 Colonial Drive
Baton Rouge, LA 70806

RE: Delta Clinic of Baton Rouge, Inc.
Event ID: MF6U11 ID: N/A Medicaid ID: N/A State ID: BO0004642

Dear Ms. Cochran:

On 02/03/2011, a health survey was conducted at the above referenced facility. At that time it was determined that the facility was out of compliance with the federal and/or state rules for Abortion Clinics. Specifically, the facility had deficient practices in the following areas:

St - S - 4405 - - Governing Body
St - S - 4415 - - Patient Records And Reports

This office has determined that your facility's failure to comply with these rules constitutes separate Class "C" violations pursuant to a final rule published by this Department in July of 2000, in that the above referenced facility's actions or inactions created a potential for harm by directly threatening the health, safety, rights or welfare of a patient(s). **As a result of these infractions, we are assessing this facility a Civil Fine of $1,000.00 for the violations under Tag S-4405 and a Civil Fine of $1,000.00 for the violations under Tag S-4415, as referenced in this letter.**

Therefore, the total amount of the Civil Fines assessed against this facility for these seperate Class "C" violations, as referenced in this letter, is $2,000.00.

Further details of these violations are included in the 02/03/2011 survey statement of deficiencies, Form CMS-2567 (previously received by this facility) which are incorporated by reference herein.

You may request an **Informal Reconsideration** of this decision to impose a civil fine. The request for Informal Reconsideration must be in writing and must be forwarded to the following address:

500 Laurel St • Suite 100 (70801-1811) • P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5292 • WWW.DHH.LA.GOV
"An Equal Opportunity Employer"

IDR Program Manager
BHSF, Health Standards Section
P. O. Box 3767
Baton Rouge, LA 70821-3767

Your request for Informal Reconsideration must be received by this office within ten (10) days from receipt of this notice letter and must include any documentation that you think demonstrates this determination was made in error. If a timely request for the Informal Reconsideration is received by this office, an Informal Reconsideration will be scheduled and you will be notified of the time and place. The reconsideration decision shall be based upon all documentation and oral testimony furnished by the provider to the department at the time of the Informal Reconsideration.

You also have the right to an **Administrative Appeal** regarding this decision. If you desire to appeal the proposed civil fine, you must file a written request within thirty (30) days after receipt of this notice letter. Your request for an Administrative Appeal must be forwarded to the following:

Division of Administrative Law
HH Section
Post Office Box 4189
Baton Rouge, LA 70821-4189

You may choose to waive or forego the right to an Administrative Reconsideration and proceed directly to an Administrative Appeal. If you choose this option, you must file a written request for an Administrative Appeal within thirty (30) days after receipt of this notice letter. Your request for an Administrative Appeal must be forwarded to the Division of Administrative Law, at the address cited in the paragraph above.

The Division of Administrative Law will require a party requesting an appeal to (1) post an appeal bond with the HH Section as provided in La. R.S. 40:2199(D), or (2) file a devolutive appeal wherein the facility pays the civil fine pending the outcome of the appeal.

Please note that the request for an Informal Reconsideration does not constitute a request for an Administrative Appeal, nor does it extend the time limit for requesting an Administrative Appeal.

Also, please note that if you do not request an Administrative Reconsideration or an Administrative Appeal, this letter constitutes notice of this Department's final decision to impose a sanction. Once the delays for filing for an Administrative Reconsideration and/or Administrative Appeal have run, the decision to impose this Civil Fine becomes final and you must remit your payment within ten (10) days to:

La. Department of Health and Hospitals
ATTN: James Taylor, Sanction Desk
Post Office Box 3767
Baton Rouge, LA 70821-3767

Upon remittance, clearly indicate that the check is for payment of a civil monetary penalty.

If you have any questions regarding this letter, please contact James H. Taylor, III at (225) 342-5457.

Sincerely,
BHSF, Health Standards Section

BY: _____
Erin Rabalais, RN
Section Chief

ER\JHT

cc: File Copy
Abortion Clinic Program Desk
Mike Chapman, Financial Management