File # 13960065
License # 863
Application # 958
Code # 2010
Check # 19167
Check Amount $ 500.00

CHARLIE CRIST
GOVERNOR

AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

RECEIVED
MAR 13 2007
Health Facility Regulation
Hospital & Outpatient Services

ANDREW J. AGWUNOBI, M.S.
SECRETARY

BUREAU OF HEALTH FACILITY REGULATION

Abortion Clinic Licensure Application

I. FACILITY IDENTIFICATION

Presidential Women's Center
Name of Clinic

100 Northpoint Parkway 33407
Street Address (location) Zip

West Palm Beach, FL Palm Beach
City State County

(561)686-3859
Telephone Number

Presidential Women's Center, Inc.
Clinic Owner (corporation, partnership, individual, etc.)

SAME
Address/P.O. Box (mailing) Zip

City State

Telephone Number

(Licensure Office Use Only)
Date Received:

TO: Bureau of Health Facility Regulation
Hospital and Outpatient Services
2727 Mahan Drive
Tallahassee, FL 32308

Under the authority of Section 390.015, Florida Statutes, and Chapter 59A-9 of the Florida Administrative Code, application is hereby made to operate an abortion clinic.

II. APPLICATION TYPE

A. Application is for (check one):

1. ( ) Initial Licensure – New Operation
2. ( ) Initial Licensure – Change of licensed operator
3. (✓) License Renewal
4. ( ) Change of Address

B. If application is for a change of address or ownership, provide date that change is to be effective.

month day year

C. If application is for license renewal, provide license period 06/14/07 - 6/13/08

III. LICENSE FEE

A check for the appropriate licensure fee is attached. ☑ Yes ☐ No

IV. PROCEDURE/DIRECTOR/HOSPITAL INFORMATION

A. Types of procedures performed (check all that apply):

1. (✓) First Trimester Abortions (The first 12 weeks of pregnancy.)
2. (✓) Second Trimester Abortions (That portion of the pregnancy following the 12th week through the 24th week.)

B. If second trimester abortions are performed, provide the following information:

1. Designated medical director and his/her State of Florida medical license number:
   Michael J. Benjamin, M.D. / ME 14909
2. The medical director has (✓) admitting privileges and/or ( ) a transfer agreement with the following licensed hospital:
   HCA Northwest Regional Hospital
   Name of Hospital
   2801 N. State Rd. 7
   Street Address (location)
   Margate, FL 33063
   City State Zip Code
   (954) 974-0400
   Telephone Number

   Coral Springs Med. Center
   3000 Coral Hills Dr.
   Coral Springs, FL 33065
   (954) 344-3000

V. LICENSED PERSONNEL ON FACILITY STAFF

Provide the information indicated on all licensed personnel, including medical staff, nurses and technicians, and all consultants. Indicate position in job title column. Attach extra sheets, if required.

FULL NAME (Surname Last)	JOB TITLE	STATUS (Employee, Contract, Consultant)	FLORIDA LICENSE REGISTRATION NUMBER
Slydell, TaRhonda	Nursing Supervisor	Employee	RN9192543
Giovanetti, Dina	Adv. Reg. Nurse Pract.	Employee	ARNP 2967172
Church, Kay	RN	Employee	RN 443582
Benjamin, Michael MD	Medical Director	Contract	ME 14909
Rodriguez, Frank MD	Physician	Contract	ME 55556

VI. OWNERSHIP INFORMATION

A. If the ownership is a firm, partnership, or association, provide the full name and address of each member. Attach additional sheets, if necessary. N/A

NAME	ADDRESS

B. If applicant is a corporation, provide the full name and address of the following. Attach additional sheets, if necessary.

1. The corporation: Presidential Women's Center, Inc.
2. Directors: Mona S. Reis
3. Officers:

President: Mona S. Reis

Vice President: Mona S. Reis

Secretary: Mona S. Reis

Treasurer: Mona S. Reis

C. Description (check one):

Not for Profit	For Profit
☐ Individual	☐ Individual
☐ Partnership	☐ Partnership
☐ Corporation	☑ Corporation

VII. GOVERNING BODY INFORMATION

A. Give the following information regarding the president of the governing body

Mona S. Reis — Executive Director

Name — Title

100 Northpoint Pkwy. West Palm Beach, FL 33407 (561)686-3859

Address — Phone Number

B. Name of person or persons under whose management or supervision the clinic will be operated (Clinic Manager).

Heidi Ott

C. Name of person or persons responsible for the financial operation of the clinic, including billing for patient care and services.

Mona S. Reis

VIII. AFFIDAVIT

I, Mona S. Reis, hereby swear (or affirm) that the statements in this application are true and correct, and that the local zoning ordinances and all other federal, state, and local laws and rules have been complied with.

Mona S. Reis, Pres
Signature of Chief Executive Officer

Subscribed and sworn to before me this 6th day of March 2007

[illegible], 2007
Notary Public

ELLEN KIMMEL
Comm# DD0605019
Expires 11/28/2010
Florida Notary Assn., Inc

SEND THE COMPLETED APPLICATION TOGETHER WITH A CHECK MADE PAYABLE TO THE AGENCY FOR HEALTH CARE ADMINISTRATION, TO:

Agency for Health Care Administration
Hospital and Outpatient Services Unit, Mail Stop 31
2727 Mahan Drive
Tallahassee, FL 32308

Phone: (850) 487-2717

INCOMPLETE APPLICATIONS ARE NOT ACCEPTABLE AND WILL BE RETURNED FOR COMPLETION.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Health Care Licensing Application

THIS FORM IS RECOMMENDED FOR USE TO COMPLY WITH THE REPORTING REQUIREMENTS PURSUANT TO CHAPTER 408, PART II, FLORIDA STATUTES. PLEASE FILL OUT THE INFORMATION AS APPLICABLE TO THE ENTITY REQUESTING LICENSURE:

1. Provider Information

Provider/Facility Type: Abortion Clinic **National Provider ID#:** _____ (if applicable)

Presidential Women's Center Inc. 59-2011653

Provider/Facility Name EIN

100 Northpoint Pkwy. West Palm Beach, FL 33407

Street Address City State Zip

Same as above

Licensee Name (if different than above) EIN (if different from above)

Licensee Mailing Address City State Zip

2. Controlling Interests of Licensee

AUTHORITY:

Pursuant to subsections 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and social security number of the applicant and each controlling interest if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest if the applicant or controlling interest is not an individual. Disclosure of your social security number is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, **do not include social security numbers on this form.** All social security numbers must be entered on the Addendum to the Application.

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Voluntary Board Member, as defined in subsection 408.803(13), Florida Statutes, means a board member of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization. The statement affirming the status of the board member must be submitted to the agency on a form provided by the agency.

A. *Individual and/or Entity Ownership of Licensee*

Provide the following information for **each person or entity (corporation, partnership, association) with 5% or greater ownership interest** in the licensee/provider. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	BUSINESS ADDRESS	TELEPHONE NUMBER	EIN	% OWNERSHIP INTEREST
Mona S. Reis	100 Northpoint Pkwy	(561) 686-	262-96-	100%
	West Palm Beach, FL	3859	1872	
	33407			

B. *Board Members and Officers of Licensee*

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members) for the licensee/provider. Attach additional sheets if necessary.

TITLE	FULL NAME	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO	Mona S. Reis	(561) 686-3859	100%
President	Mona S. Reis	"	
Vice President	Mona S. Reis	"	
Secretary	Mona S. Reis	"	
Treasurer	Mona S. Reis	"	
Other:			

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Voluntary Board Member, as defined in subsection 408.803(13), Florida Statutes, means a board member of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization. The statement affirming the status of the board member must be submitted to the agency on a form provided by the agency.

A. *Individual and/or Entity Ownership of Licensee*

Provide the following information for **each person or entity (corporation, partnership, association) with 5% or greater ownership interest** in the licensee/provider. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	BUSINESS ADDRESS	TELEPHONE NUMBER	EIN	% OWNERSHIP INTEREST
Presidential Women's Center	100 Northpoint Pkwy West Palm Beach, FL 33407	(561)686-3859	59-2011653	100%

B. *Board Members and Officers of Licensee*

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members) for the licensee/provider. Attach additional sheets if necessary.

TITLE	FULL NAME	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO	Mona S. Reis	(561)686-3859	100%
President	Mona S. Reis		
Vice President	Mona S. Reis		
Secretary	Mona S. Reis		
Treasurer	Mona S. Reis		
Other:			

C. *Voluntary Board Members and Officers of Licensee*

Provide the following information for **each person that serves as a voluntary board member** for the licensee/provider. Attach additional sheets if necessary.

FULL NAME	BUSINESS ADDRESS	TELEPHONE NUMBER	AFFIDAVIT ATTACHED Yes / No
	N/A		

3. Management Company Controlling Interests

If a company other than the licensee manages the licensee/provider, complete the following information:

A. *Individual and/or Entity Ownership of Management Company*

Provide the following information for **each person or entity (corporation, partnership, association) with 5% or greater ownership interest** in the management company. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	BUSINESS ADDRESS	TELEPHONE NUMBER	EIN	% OWNERSHIP INTEREST
	N/A			

B. *Board Members and Officers of Management Company*

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members) for the management company. Attach additional sheets if necessary.

TITLE	FULL NAME	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO			
President			
Vice President	N/A		
Secretary			
Treasurer			
Other:			

C. *Voluntary Board Members and Officers of Management Company*

Provide the following information for **each person that serves as a voluntary board member** for the management company. Attach additional sheets if necessary.

FULL NAME	BUSINESS ADDRESS	TELEPHONE NUMBER	AFFIDAVIT ATTACHED Yes/No
	N/A		

4. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), Florida Statutes, the Agency may take action against the applicant, licensee, or a licensee subject to this part which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless a repayment plan is approved by the agency.

A. Are there any incidences of outstanding fines, liens or overpayments as described above?

YES ☐ NO ☒

B. If yes, please complete the following for each incidence (attach additional sheets if necessary): N/A

1. Amount: $_____
2. Assessed by: ☐ Agency for Health Care Administration
   ☐ Centers for Medicare and Medicaid Services
3. Date of related inspection, application, or overpayment period if applicable: _____
4. Due date of payment: _____
5. Is there an appeal pending from a Final Order? YES ☐ NO ☐
6. Please attach a copy of the approved repayment plan if applicable.

5. Affidavit

I, Mona S. Reis, hereby swear or affirm that the statements in this application are true and correct.

Mona S. Reis, Pres. — Signature of Licensee or Authorized Representative

President — Title

STATE OF FLORIDA
COUNTY OF Palm Beach

Sworn to and subscribed before me this 6 day of March 2007 by Mona Reis.

This individual is personally known to me or produced the following identification: _____

ELLEN KIMMEL
Comm# DD0605019
Expires 11/28/2010
Florida Notary Assn., Inc

Notary Public

NOTARY SEAL: