State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

January 28, 2025 **Sent Via Email**

Alex Presman
Warrior Service Company, LLC
10191 Bunsen Way
Louisville, Kentucky 40299

Facility Type: Home Medical Equipment

Dear Alex Presman:

It is my pleasure to inform you that your application for licensure of Warrior Service Company, LLC has been initially approved for providing Home Medical Equipment services in all counties in Tennessee; effective January 28, 2025. The license number shall be 1491. For this initial approval to become final and permanent, your application must be ratified by the commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for February 26, 2025 . **You are hereby authorized to commence operation pending the final decision of the Commission** No further action is necessary on your part currently.

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The West Tennessee Regional Office phone number is 731-984-9684 .

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov

cc: West Tennessee Regional Administrator

HFC

RECEIVED
By Niraj Soni at 11:06 am, Nov 18, 2024

WTRO/ITSD
APP # 23300
File # 1491

HOME MEDICAL EQUIPMENT

APPLICATION FOR INITIAL LICENSURE

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html. Please check this website periodically for updates.

Name of the Facility/Agency WARRIOR SERVICE COMPANY LLC

Location of the Facility:

Street 10191 BUNSEN WAY City LOUISVILLE

County JEFFERSON State KENTUCKY Zip 40299

Phone Number (800) 448-4874 Fax Number ( ) N/A

Twenty-four (24) Hour Emergency Phone Number (800) 448-4874

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (800) 448-4874

E-Mail Address AP@WARRIORSERVICES.ORG

Does your facility have a physical location in the state of Tennessee? Yes ____ No ✓

Administrator Information:

Administrator ALEX PRESMAN

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement, or fraud)? Yes ____ No ✓

If yes, what charge(s)? ____

Location of Conviction ____ (City) ____ (County) ____ (State) Date ____

Mailing address if different from the Facility location address:

Name WARRIOR SERVICE COMPANY LLC

Street 2112 S CONGRESS AVE STE 200

City PALM SPRINGS State FLORIDA Zip 33406

Ownership of Building:

Name ELDER CONSTRUCTION INC Phone Number (502) 475-0064

Street 10197 BUNSEN WAY

City LOUISVILLE State KENTUCKY Zip 40299

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*

Johnson,Sullivan,Hancok,Campbell,Claiborne,Clay,Fentress,Scott,Pickett,Macon,Sumner,Robertson,Montgomery,Stewart,Henry,Weakley,Obion,Lake,
Dyer,Gibson,Carroll,Benton,Humpreys,Houston,Dickson,Cheatham,Davidson,Wilson,Smith,Jackson,Putnam,Overton,Morgan,Anderson,Union,Trousdale

2. Number of branch offices: 0

Address of each branch office: *(If additional space is needed, please use a separate page)*

3. **Provide proof of the ability to meet the financial needs of the facility.**

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

✓ Individual _____ Partnership _____ Corporation _____ Limited Liability Company

_____ Church Related _____ Government/County _____ Other

b. Check one: For Profit ✓ Non-profit _____

c. Legal Entity checked in 1.a:

Name WARRIOR SERVICE COMPANY LLC Phone Number (800) 448-4874

Street 2112 S CONGRESS AVE STE 205

City PALM SPRINGS State FLORIDA Zip 33406

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

Name	Street	City, State, Zip
ALEX PRESMAN	17610 SPARKLING RIVER RD	BOCA RATON FL 33496

(If additional space is needed, please use a separate sheet)

e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes _____ No _____ N/A

f. If no to e., who has said authority? _____

2. a. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.**

Yes JOINT COMMISSION No 573366 Expiration Date 11/05/2024

3. If you have a parent company, please provide the following information:

Name_____ Phone Number (____)_____

Address _____

4. a. If a corporation, is there a holding company? Yes _____ No _____

b. If yes, list the name, address and phone number of the holding company:

Name N/A Phone Number (____)_____

Street_____

City_____ State_____ Zip_____

5. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes_____ No ✓

b. If yes, list names and addresses of all such facilities:

_____

_____

6. a. Do you have a contract with a management firm to operate this facility? Yes_____ No ✓

If yes, specify dates: From_____ To_____

b. If yes, please specify name of firm: _____

Phone Number (___)_____

_____

Street City, State, Zip

7. For any item in (7) a-h below, please identify, explain and provide documentation of the item(s) noted if response is "Yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states on the list in question (5.b.) above, OR the management firm listed in question (6.) above; been subjected to any of the following within the last (5) years:

a. Licensure

i) denied a license ? Yes____No ✓

ii) had a license suspended or revoked by any state licensure agency? Yes____No ✓

iii) been subject to a final order or judgment in a state licensure action? Yes____No ✓

b. Convictions

i) convicted of a criminal offense related to that person's involvement in any program under any state or Federal health care program (including Medicare, Medicaid, and Tricare)? Yes____No ✓

c. Exclusion

i) excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes____No ✓

(Note: "Excluded" is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare program).

d. **Termination/Suspension**

i) suspended or terminated from participation in Medicare or Medicaid/TennCare programs? Yes____ No✓

(Note: This would include involuntary termination of a nursing facility or skilled nursing facility by the Centers for Medicare and Medicaid Services (CMS) or state Medicaid agency).

e. **Fraud and Abuse**

i) paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? Yes No✓

f. **Corporate Integrity Agreement**

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes____ No✓

(Note: If yes, provide a copy of CIA)

g. **Bankruptcy**

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes____ No✓

h. **Civil Monetary Penalty (CMP)**

i) paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than $250,000.00 as a result of an enforcement action during a survey? Yes____ No✓

Failure to provide true and correct copies of any documents related to the items list in 7(a-h) listed above may be grounds for referral of the application for special consideration, and/or may be grounds for disciplines.

If the applicant answered "Yes" to any of the questions (a)-(h) above, please provide copies of any documentation associated with the event and/or sanction. The documentation should provide the Health Facilities Commission with sufficient information regarding the nature of the event and/or sanction, the current status of the issue, as well as details regarding what corrective action shave been implemented (as applicable).

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

☐ By checking this box, you acknowledge that you will ensure access to a secure online portal is available to Health Facilities Commission surveyors in order to conduct all necessary and required surveys related to licensure.

Applicant Signature	OWNER Title or Position	10/08/2024 Date

FLORIDA

STATE OF ~~TENNESSEE~~

County of Palm Beach

The above named applicant (print name) Alex Presman, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this 8th day of October (Month) 2024 (Year)

Notary Public State of Florida
Nicole M Dwyer
My Commission HH 399597
Expires 5/17/2027

Notary Public: Nicole Dwyer

My commission expires: 5/17/2027

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) **$1,404**

STATE OF TENNESSEE
Health Services and Dev Agency
Office:Andrew Jackson, 8t
11/6/2024 11:17 AM

Cashier: JENNB0621001
Batch #: 1648610
Trans #: 12

==========

Health Care Facilities

Receipt #: 38960614 $1,404.00
HA15 HCF $1,404.00
Payment Total: ==========
$1,404.00
Transaction Total:

$1,404.00
Check 21

Thank you for your payment.
Have a nice day!

1529

WARRIOR SERVICE COMPANY
SERVING THOSE WHO SERVED
2112 S CONGRESS AVE 200
PALM SPRINGS, FL 33406
AP@WARRIORSERVICES.ORG

Bank of America.
ACH R/T 063100277
63-27/631

10/18/2024

PAY TO THE ORDER OF Tennessee Health Facilities Commission $**1,404.00

One thousand four hundred four and 00/100********** DOLLARS

Tennessee Health Facilities Commission
502 Deaderick St
Nashville, TN 37243

MEMO

AUTHORIZED SIGNATURE

Security features. Details on back.

State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

November 18, 2024 Sent Via Email

Alex Presman
Warrior Service Company, LLC
10191 Bunsen Way
Louisville, Kentucky 40299

Dear Alex Presman:

This is to acknowledge receipt of your application and fee to apply for licensure of Warrior Service Company, LLC. Please review the instruction sheet that you received with the application to apply for licensure so that you are aware of the process for obtaining licensure of your facility. If a certificate of need is required to provide services, you will need to contact *Health Services and Developmental Agency* at (615) 741-2364.

Please remember that if you are applying for licensure of a facility that requires an architectural plans review contact Plans Review for complete and details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey. **For Homes for the Aged facilities specifically; TCA-368-11-202 allows "schematics shall be submitted to the department for approval of plans and specifications, converting and existing single family dwelling" with six (6) or less beds.**

It is your responsibility to contact the East Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to Kathy Ziegler , Regional Administrator, . If you would like to fax the request to the fax number is 731-427-0417.

Your application and fee will be held in a pending status until you are recommended by the Regional Office for licensure. Once the recommendation for licensure is received from the regional office, your facility will receive a letter for "Initial Approval." Admission of patients MAY NOT occur until the facility's receipt of the "Initial Approval" letter. Your application will be presented before the Health Facilities Commission for ratification and final approval at the next regularly scheduled commission meeting. Your facility CAN operate once you receive the "Initial Approval."

This application will only be good for one (1) year from the date of receipt. If the initial licensure has not occurred within that one (1) year period, you will be required to submit a new application and fee unless you have contacted our office in writing extending your application.

If a certificate of need is required prior to obtaining a license for this facility the application file will be closed the day following the expiration date of the certificate of need.

Should you have any questions or if I can be of assistance to you, please email me at Niraj.Soni@tn.gov

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov