State of Tennessee
Health Facilities Commission
Andrew Jackson State Building
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

March 16, 2026 Sent Via Email

Mary (Beth) Foster (admin@energyworkershomehealthservices.com)
Energy Workers Home Health
950 Main Street
Wartburg, TN 37887

Facility Type: Home Health Agencies

Dear Mary Foster:

It is my pleasure to inform you that your application for licensure of Energy Workers Home Health located at 950 Main Street, Wartburg, TN 37887 has been initially approved effective March 13, 2026. The license number shall be 714. 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 April 22, 2026. **You are hereby authorized to commence operation pending the final decision of the Commission**.

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The East Regional Office phone number is 865-594-0730.

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's 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,
Eddie J. Stewart
Eddie J. Stewart
Health Facilities Program Manager
Health Facilities Commission
Licensure and Regulation Unit

cc: East Tennessee Regional Office

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: ___HHA_ License # (if applicable): ___714_____County: Morgan

Initial _____X_____ Renovation _____ Satellite/Off Campus Location _____

Physical Plant/Services/New Addition _____ Relocation/Replacement Facility_____
(Circle One) **(Circle One)**

Facility Name: BB Golden Care dba Energy Workers Home Health 950 Main Street, Suite E, Wartburg, TN 37877

Application and fee on file in Central Office (CO)? Yes __X__ No __ CON #: ___Project #: __Phase: _____ of __

Facility approved for Home Health Services: Providing Home Health services in all counties in Tennessee.

Sprinklered: _____(Full 100%) Partial: _____(%)

Licensed bed count from: _____0 to ___0___ Number of beds increased/decreased: _____0_____

If secured unit, number of beds in unit: ____N/A_____ If Alzheimer's unit, number of beds in unit: _____
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor:_____Jessika Lilly, RN_____ Date: __3/13/2026_____

Fire Safety: NA_____ Date: _____

CD Approved: Yes _____ No___ N/A _x____ Health Survey Required: Yes__X__ No ____; if Yes, please indicate which region: ___EAST_____

.

Facility's Letter of Notification received in Licensure: Yes _X____No ____
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc.) approved and received in regional office: Yes ____ No ____ N/A
(NOTE: With exception of Initial Licensure Approvals)

Effective date: 3/13/2026 Licensure is recommended: Yes _X__ No ____
(Completed by Central Office Licensure Staff)

Tom A. Lane, RN, BSHL 3/13/2026
Regional Administrator/Facilities Construction Director or Designee Date

Eddie Stewart 3/13/2026
Licensure Program Unit Staff Date

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

November 14, 2025 Sent Via Email

Mary Beth Foster
Energy Workers Home Health
950 Main Street
Wartburg, TN 37887

Dear Mary Beth Foster:

This is to acknowledge receipt of your application and fee to apply for licensure of Energy Workers Home Health. 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 Facilities Commission at (615) 741-2364.

Please remember that if you are applying for a facility that requires architectural plan 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 East Tennessee, Regional Administrator, 7175 Strawberry Plans, Suite 103 Knoxville, Tennessee 37914. If you would like to fax the request to Debra Verna the fax number is 865-594-5298.

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 Board for Licensing 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.

In the event that 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 call me at (615) 741-7221 or you may email me at Angela.A.Tyler@tn.gov.

Sincerely,

Angela Tyler

Angela Tyler

ETRO | File # 714
ITSD | APP # 13205

received 11/6/25 acct

HFC

HOME HEALTH SERVICES
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 Energy Workers Home Health PLLC

Location of the Facility:

Street 950 Main Street City Wartburg

County Morgan State TN Zip 37887

Phone Number (423) 346-4616 Fax Number ( )

Twenty-four (24) Hour Emergency Phone Number (423) 346-4616

E-Mail Address admin@energyworkershomehealthservices.com

Administrator Information:

Administrator Mary Elizabeth Foster

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, fraud)? Yes ____ No X

If yes, what charge(s)? ____

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

Mailing address if different from the Facility location address:

Name ____

Street ____

City ____ State ____ Zip ____

Ownership of Building:

Name Dave Hamby Phone Number (865) 850-3336

Street 1177 Bob Armes Circle

City Wartburg State TN Zip 37887

1. Check type: Hospital Based ____ Nursing Home Based ____ Free Standing X

2. Check type: Licensed only Agency X Licensed/Medicaid Certified ____

Building/office suite will be leased by Mary Foster.

3. Check type of services provided:

a. Skilled Nursing	✓	f. Home Health Aid Services	____
b. Physical Therapy	____	g. Medical Supplies and Appliances	____
c. Occupational Therapy	____	h. Homemaker Services	____
d. Speech Therapy	____	i. Other (please specify)	____
e. Medical Social Services	____		

4. Do you have a Certificate of Need (CON)? Yes____ No ✓

If yes, what is the geographic area served by the Agency: (list county or counties) If additional space is needed, please use a separate page.

_____

_____

5. Do you provide services to a pediatric population? Yes ____ No X

If yes, what counties? _____

6. Is your agency a provider in the EEOICPA federal program? Yes ✓ No ____

If yes, what counties? See attached CON Exemption form

7. 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 [redacted] Corporation ____ Limited Liability Company ✓

Partnership

Church Related ____ Government/County ____ Other ____

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

c. Legal Entity checked in 1.a:

Name BB Golden Care P-LLC Phone Number (423) 346-4646

Address 950 Main Street Wartburg TN, 37887

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

Mary Elizabeth Foster 1190 Main Street Wartburg TN 37887
Name Street City, State, Zip

Brittney Makayla King 2465 Kingtown Rd Winfield TN 37892
Name Street City, State, Zip

(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 including but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.**

Yes _____ No X Expiration Date _____

3. Is this facility chain affiliated? Yes _____ No X

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

Name _____ Phone Number (____) _____

Address _____

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

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

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

6. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes _____ No X

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

_____

_____

7. a. Do you have a contract with a management firm to operate this facility? Yes _____ No X

If yes, specify dates: From _____ To _____

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

Phone Number (____) _____

_____

Street City, State, Zip

8. For any item in (8) 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 (6.b.) above, OR the management firm listed in question (7.) above; been subjected to any of the following within the last (5) years:

a. Licensure

i) denied a license ? Yes____No X

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

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

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 X

c. Exclusion

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

(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_X_

(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_X_

f. Corporate Integrity Agreement

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes____No_X_

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

g. Bankruptcy

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes____No_X_

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_X_

Failure to provide true and correct copies of any documents related to the items list in 8(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.

Mary Foster — Applicant Signature

Administrator — Title or Position

10/3/25 — Date

STATE OF TENNESSEE

County of Morgan

The above named applicant (print name) Mary Elizabeth Foster, 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 3 day of October (Month) 2025 (Year)

Notary Public: Cheryl L Collins

My commission expires: 12/16/2028

CHERYL L COLLINS STATE OF TENNESSEE NOTARY PUBLIC MORGAN COUNTY

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

Tennessee Department of Health
Cash Listing Report

Client:	343 - DEPARTMENT OF HEALTH		**Origin:**	Deposit	**Fiscal Year:** 2026
Batch #:	731	**Total $ Entered:** $ 1,404.00	**Deposit #:**		**Deposit Date:**
# Receipt:	1	**Receipts Entered:** 1	**Total:**	$ 1,404.00	**Status:** Opened

Receipt #	DLN	Received	Disp	Pmt	Bad Check?	Unassigned	Prof	Remitted By / Beneficiary	File #	License #	Assigned
615	40819792	$ 1,404.00	DEP	CHK		$ 1,404.00					
							534	ENERGY WORKERS HOME HEALTH	714		
Total:		$ 1,404.00				$ 1,404.00					

State of Tennessee
Health Facilities Commission
502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

INITIAL NOTIFICATION OF HOME HEALTH ACCREDITATION FOR CON EXEMPTION

Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a health care institution or initiates any service specified in T.C.A. 68-11-1607 (a) (3) pursuant to the exemption provided in T.C.A. 68-11-1607 (r) or T.C.A. 68-11-1607 (r) This form must be emailed to hsda.staff@tn.gov.

1. **REPORTING DATE:**

12/9/25

2. **CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION**

MaryBeth Foster (Name)
Energy Workers Home ~~Health~~ (Company)
950 Main Street (Mailing Address)
Wartburg TN 37887 (City) (State) (Zip)

Administrator (Title)
admin@energyworker (Email Address)
423-346-4663 (Telephone Number)
423-346-5758 (Fax Number)

3. **IF SEEKING THE ESTABLISHMENT OF A HOME HEALTH AGENCY UNDER EXEMPTION, DATE OF LICENSE SUBMISSION:**

12/2/25

4. **IF CURRENTLY LICENSED, PROVIDE LICENSE #:**

LIST CURRENT LICENSED COUNTIES:

COUNTIES LICENSED UNDER EEOICPA:

COUNTIES LICENSED UNDER PEDIATRIC

COUNTIES LICENSED AS HOME INFUSION ONLY:

LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:

5. **DESCRIPTION OF EXEMPTED ACTIVITY:**

Skilled Nursing | Home Health | Private Duty

LIST OF EXEMPTED COUNTIES TO BE ADDED UNDER THE FOLLOWING TYPES:

PEDIATRIC:

EEOICPA: Maury, Giles, Smith, DeKalb, Rutherford, Bedford, Trousdale, Wilson, Moore, Lincoln, Sumner, Davidson, Williamson, White, Vanburen, Sequatchie, Clay, Jackson, [redacted], Warren, Coffee, Fannin, Franklin, Macon, Knox, Blount, Sevier, Hamblen, Washington, Hamilton, Anderson, Sullivan, Jefferson, Grainger, Morgan, Loudon, Claiborne, Johnson, Greene, Cumberland, [redacted], Marion, Fentress, Union, Monroe, Cocke, Campbell, Bradley, Hawkins, Rhea, [redacted], Scott, McMinn, Roane, Hancocke, Carter, Meigs, Unicoi, [redacted], Bledsoe, Pickett, Overton, Putnam

6. **NAME AND ADDRESS OF PROVIDER**

Energy Workers Home Health
(Name)

950 Main Street
(Street Address)

Wartburg TN 37887
(City) (State) (Zip)

7. **ACCREDITATION (must be completed within 2 years of initial licensure)**

Please Check

- ☐ Community Health Accreditation Program, Inc.
- ☒ Accreditation Commission for Health Care and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives
- ☐ Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects;

I UNDERSTAND THAT A HOME HEALTH AGENCY THAT PROVIDES HOME HEALTH SERVICES WITHOUT A CERTIFICATE OF NEED TO PEDIATRIC AND/OR EEOICPA PATIENTS THAT FAILS TO COMPLY WITH THE ACCREDITATION REQUIREMENTS IS SUBJECT TO LICENSURE SANCTIONS.

Signature of authorized agent

12/9/25
Date

Mary Beth Foster
Printed Name