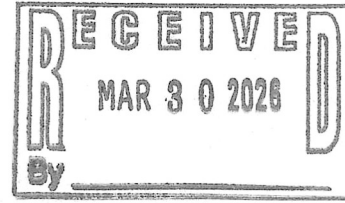




App # 23947
F-1571
ETRO/FTSD



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 Aeroflow Direct LLC dba CPAPSupplies.com

Location of the Facility:

Street 3165 Sweeten Creek Road City Asheville

County Buncombe State NC Zip 28803-2115

Phone Number (866) 298-6482 Fax Number (877) 881-1291

Twenty-four (24) Hour Emergency Phone Number (N/A) 866-298-6482 (CNS) Aeroflow provides voicemail service and calls will be returned the next business day.

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

E-Mail Address licensing@aeroflowinc.com

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

Administrator Information:

Administrator Lauren Bennett

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 X

If yes, what charge(s)? N/A

Location of Conviction N/A (City) (County) (State) Date

Mailing address if different from the Facility location address:

Name N/A Same (CNS)

Street

City State Zip

Ownership of Building:

Name N/A Aeroflow Direct dba CPAPSupplies.com Phone Number (866-298-6482) (CNS)

Street 3165 Sweeten Creek Rd

City Asheville State NC Zip 28803

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

All counties in Tennessee, out of State North Carolina

2. Number of branch offices: 0

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

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 Aeroflow Direct LLC dba CPAPSupplies.com Phone Number (866) 298-6482

Street 3165 Sweeten Creek Road

City Asheville State NC Zip 28803

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

See attached.

Name	Street	City, State, Zip
------	--------	------------------

Name	Street	City, State, Zip
------	--------	------------------

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? N/A

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

Yes No Expiration Date 12/30/2028

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

Name Aeroflow Inc. dba Aeroflow Healthcare Phone Number (888) 345-1780

Address 3165 Sweeten Creek Road, Asheville, NC 28803-2115

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 _____ 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:

Aeroflow Inc. - 65 Beale Road, Arden, NC 28704-9213 Aeroflow Inc. - 6 Commerce Way, Arden, NC 28704-9712

Aeroflow Inc. - 5 Worth Circle, Suite A, Johnson City, TN 37601-4339

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 have 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

President
Title or Position

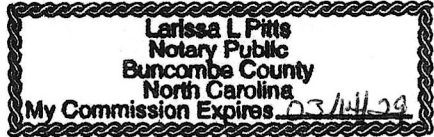
3/13/2026
Date

STATE OF TENNESSEE

County of Buncombe

The above named applicant (print name) Lauren Bennett, 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 13th day of March 2020
(Month) (Year)



Notary Public: Larissa L Pitts

My commission expires: 03/14/2029

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



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

April 29, 2026

Sent Via Email

Lauren Bennett
Aeroflow Direct, LLC dba CPAP Supplies.com
3165 Sweeten Creek Road
Asheville, North Carolina 28803

Facility Type: Home Medical Equipment

Dear Lauren Bennett:

It is my pleasure to inform you that your application for licensure of Aeroflow Direct, LLC dba CPAP Supplies.com located at 3165 Sweeten Creek Road, Asheville, NC 28803 has been initially approved for providing DME/HME services in all counties in Tennessee effective April 29, 2026 . The license number shall be 1571. 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 May 27, 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 Tennessee Regional Office phone number is 865-594-9396 .

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,

Niraj Soni

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



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1571 County: Buncombe

Initial X Renovation _____ Satellite/Off Campus Location _____
Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: Aeroflow Direct LLC dba CPASupplies.com
Address: 3165 sweeten creek road Asheville NC 28803-2115

Application and fee on file in Central Office (CO)? Yes X No _____ CON #: _____ Project #: _____ Phase: _____ of _____

Facility approved for Home Medical Equipment (HME): Providing DME/HME 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: Nancy Mullins RN Date: 04/20/26

Fire Safety: See attached application 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 _____ No X
(Completed by Central Office Licensure Staff)

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

Effective date: April 29, 2026
(Completed by Central Office Licensure Staff)

Licensure is recommended: Yes x No _____

Tom Lane RB 4/23/2026
Regional Administrator/Facilities Construction Director or Designee Date
Niraj Soni 4/29/2026
Licensure Program Unit Staff Date



Aeroflow Health
3165 Sweeten Creek Road
Asheville, NC 28803-2115

Aeroflow Direct LLC dba CPASupplies.com
NPI 1306704895 / TIN 88-0607104

Ownership Information

Aeroflow Inc. dba Aeroflow Healthcare (100% Direct)
3165 Sweeten Creek Rd
Asheville, NC 28803
Buncombe County

Casey L. Hite, Individual (67% Indirect)
DOB: 01/27/1977
3165 Sweeten Creek Rd
Asheville, NC 28803
Buncombe County

The Casey L. Hite Dynasty Irrevocable Trust (30% Indirect)
214 North Tryon St., 33rd Floor
Charlotte, NC 28202
Mecklenburg County

JIH Irrevocable Trust (3% Indirect)
721 Streamside Dr.
Arden, NC 28704
Buncombe County



Aeroflow Health
3165 Sweeten Creek Road
Asheville, NC 28803-2115

Aeroflow Direct LLC dba CPASupplies.com
NPI 1306704895 / TIN 88-0607104

Corporate Officers and Managing Employees

Lauren Bennett, President
570 S. Phillips Road
Columbus, NC 28722-5500
County: Polk
DOB: 11/21/1985

Joshua Hill, Vice President
721 Streamside Drive
Arden, NC 28704-9146
County: Buncombe
DOB: 03/23/1977

Scott Sonnone, Chief Financial Officer
210 Robinhood Road
Asheville, NC 28804-1620
County: Buncombe
DOB: 06/16/1970

Ryan Bullock, Secretary
118 Harrop Dun Court
Biltmore Lake, NC 28715-7901
County: Buncombe
DOB: 05/11/1979

CERTIFICATE of ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

Aeroflow Direct LLC
d/b/a CPAPSupplies.com
ASHEVILLE, NORTH CAROLINA

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

DMEPOS

Home/Durable Medical Equipment Services

Accreditation #99428

FROM *March 2, 2026*, THROUGH *December 30, 2028*



A handwritten signature in black ink, appearing to read 'John G. ...', is written over a horizontal line.

PRESIDENT & CHIEF EXECUTIVE OFFICER

A handwritten signature in black ink, appearing to read 'Brook Helbach', is written over a horizontal line.

CHAIR OF THE BOARD OF COMMISSIONERS