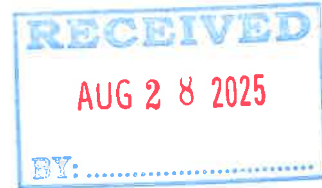
ETRO | FTSD
F-#1534
App # 23663



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 DME Supply USA LLC

Location of the Facility:

Street 720 Moorefield Park Drive Suite 202 City N Chesterfield

County Chesterfield State VA Zip ~~23226~~ 23234 (NS)

Phone Number (804) - 353 - 4240 Fax Number (844) - 662 - 8650

Twenty-four (24) Hour Emergency Phone Number (804) - 353 - 4240

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (804) - 353 - 4240

E-Mail Address Licensing@lincare.com

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

Administrator Information:

Administrator Jennifer Styles

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)? ____________________

Location of Conviction ____________________ Date ________
(City) (County) (State)

Mailing address if different from the Facility location address:

Name Lincare Inc. Licensing Dept c/o DME Supply USA, LLC

Street P.O Box 9004

City Clearwater State Florida Zip 33758

Ownership of Building:

Name Crenshaw-Singleton Properties LLC Phone Number (804) - 643 - 0009

Street 1011 E Main St #206

City Richmond State VA Zip 23219

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

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 X Limited Liability Company

   ____Church Related ____Government/County ____Other

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

   c. Legal Entity checked in 1.a:

   Name Lincare Inc Phone Number (727)-431-8120

   Street 19387 US Highway 19 N

   City Clearwater State FL Zip 33764

   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
Jeffrey Barnhard, CEO	19387 US Highway 19 N	Clearwater, FL, 33764
Carlos Paiva, CFO	19387 US Highway 19 N	Clearwater, FL, 33764
Andrew Sarantapoulas VP of Business Process Improvement	19387 US Highway 19 N	Clearwater, FL, 33764

   (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 X No ____

   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 X No ____ Expiration Date 12/15/2027

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

Name Lincare Holdings Inc Phone Number (729)-431- 8120
Address 19387 US Highway 19 N

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

b. If yes, list the name, address and phone number of the holding company:
Name Lincare Holdings Inc. Phone Number (727)-431- 8120
Street 19387 US Highway 19 N
City Clearwater State FL Zip 33764

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 X
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 X
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 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 7(a-h) listed above may be grounds for referral of the application for special consideration, and/or may be grounds for disciplines.

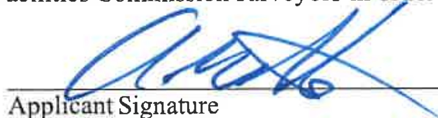
If the applicant answered "Yes" to any of the questions (a)-(h) above, please provide copies of any documentation associated with the event and/or sanction. The documentation should provide the Health Facilities Commission with sufficient information regarding the nature of the event and/or sanction, 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 | VP of Business Process Improvement — Title or Position | 8/26/25 — Date

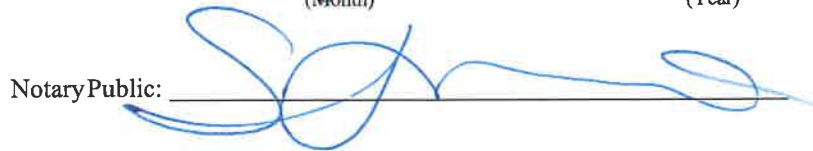
STATE OF ~~TENNESSEE~~ Florida

County of Pinellas

The above named applicant (print name) Andrew Sarantapoulas, 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.

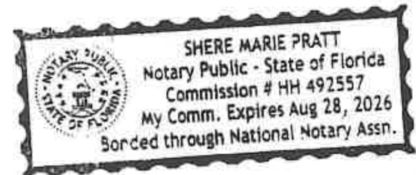
Subscribed to and sworn to on this 27th day of August (Month) 2025 (Year)

Notary Public:



My commission expires: ____________

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 8, 2026 Sent Via Email

Jennifer Styles
Lincare Inc
C/O DME Supply USA LLC
Po Box 9004
Clearwater, FL 33758
Attn: Licensing Dept

Facility Type: Home Medical Equipment

Dear Jennifer Styles:

It is my pleasure to inform you that your application for licensure of DME Supply USA, LLC located at 720 Moorefield Park Drive, Chesterfield, Virginia 23226 has been initially approved for Out of State Home Medical Equipment Provider serving all counties of Tennessee effective April 8, 2026 . The license number shall be 1534 . 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 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'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): #1534 County: Out of State HME Provider

Initial X Renovation ___ Satellite/Off Campus Location ___

Physical Plant/Services/New Addition ___ (Circle One) Relocation/Replacement Facility ___ (Circle One)

Facility Name: DME Supply USA, LLC

Address: 720 Moorefield Park Drive, Suite 202 City: North Chesterfield ZIP Code: 23234

Application and fee on file in Central Office (CO)?: Yes X No ___ CON #: ___

Project #: ___ Phase: ___ of ___

Facility approved for (if satellite/off campus site include address): Out of State Home Medical Equipment Provider serving all counties in Tennessee

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

Licensed bed count from: ___ to ___ Number of beds increased/decreased: ___

If secured unit, number of beds in unit: ___ 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: Celia Skelley RN PHNCI [signature] Date: 2/17/2026

Fire Safety: ___ Date: ___

CD Approved: Yes ___ No ___ N/A ___ Health Survey Required: Yes X No ___

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 ___ NA
(NOTE: With exception of Initial Licensure Approvals)

Effective date: April 8, 2026 Licensure is recommended: Yes X No ___
(Completed by Central Office Licensure Staff)

KZl Rhonda Rogers 3/2/2026
Regional Administrator/Facilities Construction Director or Designee Date

Niraj Soni 4/8/2026
Licensure Program Unit Staff Date

Administrator is Jennifer Styles: JHines2@lincare.com
Please send copy to Mitch Huett: MHuett@lincare.com

CHAP Community Health Accreditation Partner

Certificate of Accreditation

This is to certify that the following organization has met the requirements of the Community Health Accreditation Partner (CHAP) Standards of Excellence, and demonstrated a commitment to providing quality patient care and services.

Lincare Inc

is therefore granted accreditation for the following:

Home Medical Equipment

Effective: 12/15/2024

Expiration: 12/15/2027

Nathan J. DeGodt
President and CEO, CHAP

Patricia Driscoll
Chair, CHAP Board of Directors

CHAP is an independent, nonprofit accrediting body for organizations providing home and community-based health care services in accordance with nationally recognized CHAP Standards of Excellence. Additional information regarding CHAP Accreditation and a listing of individual accredited organizations can be obtained by visiting www CHAPinc.org.

Customer ID: 2001083