Recieved 2/18/26
App#23892
F-1560
WTRD/ITSD/PR

HFC

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 EBI, LLC

Location of the Facility:

Street 1 Gatehall Drive Suite 303 City Parsippany

County Morris State New Jersey Zip 07054

Phone Number (800) 526 2579 x 3068 Fax Number (973) 257-7841

Twenty-four (24) Hour Emergency Phone Number (201) 341-3044 (NS)

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (800) 526 2579

E-Mail Address payer.relations@ebibonestimulator.com

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

Administrator Information:

Administrator Vincent Binetti

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 _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name Same (NS)

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name Lakewood Capital, LLC ~~Suite 100~~1 (NS) Phone Number ( ) 203 604-0863

Street 7 Old Field Rd Suite 1001 (NS)

City Norwalk (NS) State CT Zip 06853

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*
All counties in Tennessee (NS)
Out of State ~~All counties in~~ New Jersey (NS)

2. Number of branch offices: N/A

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 EBI, LLC Phone Number (800)526 2579

Street 1 Gatehall Drive Suite 303

City Parsippany State NJ Zip 07054

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
Vincent Binetti	434 Webster Ave	Township of Washington, NJ 07676-5238

(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 X

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

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 ACHC No _____ Expiration Date 11/14/2028

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

Name N/A Phone Number (____)

Address

4. 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

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	CFO/ COO Title or Position	2-17-26 Date

STATE OF ~~TENNESSEE~~ New Jersey

County of Morris

The above named applicant (print name) Vincent Binetti, 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 17 day of February (Month) 2026 (Year)

Notary Public: Doreen M Cerroffo

My commission expires: 4/25/27

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

Vincent Binetti
EBI, LLC
1 Gatehall Drive Suite 303
Parsippany, New Jersey 07054

Facility Type: Home Medical Equipment

Dear Vincent Binetti:

It is my pleasure to inform you that your application for licensure of EBI, LLC located at 1 Gatehall Drive Suite 303, Parsippany, New Jersey 07054 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 1560 . 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

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1560 County: Out of State

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: EBI, LLC

Address: 1 Gatehall Drive,Suite 303 City: Parsippany, NY Zip Code: 07054

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 of 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 CSS Date: 3/24/26

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A____

Health Survey Required: Yes_X___ No__; if Yes, please indicate which region: _WTN_____

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)

KZ | Rhonda B. Rogers 3/30/2026
Regional Administrator/Facilities Construction Director or Designee Date

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

Administrator is Vincent Binetti: Vincent.Binetti@ebibonestimulator.com
Please send copy to Aisha Barazi: Aisha.barazi@ebibonestimulator.com

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

EBI, LLC

PARSIPPANY, NEW JERSEY

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 #31149

FROM *November 15, 2025* THROUGH *November 14, 2028*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIR OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC