



Received 9/25/25
WTRQ FTSD
F-1540
HOME MEDICAL EQUIPMENT

APP# 23700

APPLICATION FOR INITIAL LICENSURE

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

Name of the Facility/Agency Inogen Inc

Location of the Facility:

Street 859 Ward Drive, Suite 200 City Goleta

County Santa Barbara State California Zip 93111

Phone Number () 805-562-0500 Fax Number () 888-306-8766

Twenty-four (24) Hour Emergency Phone Number () 877-466-4364

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week () 877-466-4364

E-Mail Address licensing@inogen.net

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

Administrator Information:

Administrator Kevin Paul Smith

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 (City) (County) (State) Date

Mailing address if different from the Facility location address:

Name Same (verified NRS)

Street

City State Zip

Ownership of Building:

Name Townsgate Business Park and Majestic Luna2 Phone Number () 800-562-2111

Street 222 E. Carrillo Street STE 101

City Santa Barbara State CA Zip 93101-7145

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*
~~All 50 states and the District of Columbia.~~ **Out of State California (NS)**
All counties in Tennessee (NS)

2. Number of branch offices: 0 **Verified NBS**
Address of each branch office: *(If additional space is needed, please use a separate page)* **Verified NBS**
~~1450 Sam Davis Road, Suite 140, Smyrna TN 37167, 600 Shiloh Road, Plano, TX, 75074 ;~~
~~1403 Weatherly Plaza SE, Suite 108, Huntsville, AL 35803 ; 2600 Parker Road, Suite 5-151, Aurora, CO 80014~~

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:

Verified NBS
Name ~~Delaware~~ **Trosen, Inc** Phone Number **805, 562-0500**
Street **859 Ward Drive, Suite 200**
City **Goleta** State **CA** Zip **93111**

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

Kevin Smith, CEO **859 Ward Drive Goleta, CA 93111**
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 **NA**

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 No Expiration Date **May 07, 2027**

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 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 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

Kevin Paul Smith

General Counsel & Executive Vice President

Title or Position

9/2/2025


Date

Massachusetts
~~STATE OF TENNESSEE~~

County of Essex

The above named applicant (print name) Kevin P. Smith, 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 2nd day of September 2025
(Month) (Year)

 **MELISSA E. NAJJAR-JAROSZ**
Notary Public
Commonwealth of Massachusetts
My Commission Expires
January 8, 2032

Notary Public: *M. E. Najjar-Jarosz*

My commission expires: January 8, 2032

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

Kevin Paul Smith
Inogen, Inc
859 Ward Drive, Suite 200
Santa Barbara, California 93111

Facility Type: Home Medical Equipment

Dear Kevin Paul Smith:

It is my pleasure to inform you that your application for licensure of Inogen Inc. located at 859 Ward Drive, Suite 200, Santa Barbara, California 93111 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 1540 . 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): 1540 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: Inogen Inc

Address: 859 Ward Drive, Suite 200 City: Santa Barbara, CA Zip Code: 93111

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: 3/17/26

Fire Safety: _____ Date: _____

CD Approved: Yes _____ No _____ N/A X Health Survey Required: Yes X No _____; if Yes, please indicate which region: WTN

Facility's Letter of Notification received in Licensure: Yes ✓ No _____
(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 ✓ No _____
(Completed by Central Office Licensure Staff)

KZ / Rhonda Lopez 3/24/2026
Regional Administrator/Facilities Construction Director or Designee Date

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

Administrator : Kevin Paul Smith: kpsmith@inogen
Please send copy to Gary Miller: gmiller@inogen.net

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

Inogen, Inc.
GOLETA, CALIFORNIA

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 #39304

FROM *May 8, 2024*, THROUGH *May 7, 2027*



PRESIDENT & CHIEF EXECUTIVE OFFICER



CHAIRMAN OF THE BOARD OF COMMISSIONERS





Inogen Inc
EIN: 330989359
859 Ward Drive, STE 200
Goleta, CA 93111-2920

September 2025

Tennessee Health Facilities Commission
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243-1102

Subject: Request for Out-of-State Home Medical Equipment License

Dear Commissioners,

I am writing on behalf of Inogen, headquartered in Goleta, California, to formally request an out-of-state Home Medical Equipment (HME) license to support our operations and patient services in Tennessee.

Our company has been in continuous operation since 2002, providing high-quality home medical equipment and services with a strong commitment to regulatory compliance and patient care. In addition to our California office, we currently maintain a properly licensed facility located at 1450 Sam Davis Road, Suite 140, Smyrna, TN 37167. This location is fully compliant with Tennessee regulations and serves as a key part of our regional operations.

We are seeking an out-of-state HME license to ensure that our Goleta office can continue to support patients residing in Tennessee, in coordination with our Smyrna location. We are prepared to submit all required documentation, fees, and assurances to meet the standards set forth by the Tennessee Health Facilities Commission.

Thank you for your consideration of our request. We have enclosed a notarized application, along with supporting documentation and payment. Please advise us of any additional steps or materials needed to proceed with the application. We look forward to continuing our service to Tennessee residents with the same dedication and professionalism that has defined our company for over two decade

Yours sincerely,

Gary Miller
Licensing Specialist II
Ph: 469-917-6704
gmiller@inogen.net