



Received 10/14/25

App # 23737

F-1542
WTRO/ETSD

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 Nu Life Med, LLC

Location of the Facility:

Street 250 N. Commercial St. Suite 3003 City Manchester

County Hillsborough State New Hampshire Zip 03101

Phone Number (603) 206-5725 Fax Number (603) 676-7878

Twenty-four (24) Hour Emergency Phone Number (603) 206-5725

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (603) 206-5725

E-Mail Address nsoucy@nulifemed.net

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

Administrator Information:

Administrator Michelle DeStefano

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

If yes, what charge(s)? _____

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

Mailing address if different from the Facility location address:

Name Nu Life Med, LLC

Street 250 N. Commercial St Suite 3003

City Manchester State NH Zip 03101

Ownership of Building:

Name Merrimack River Mills, LLC Phone Number (603) 623-9229

Street 670 N. Commercial St Suite 303

City Manchester State NH Zip 03101

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*
Hamilton, Bradley, Polk, Marion, McMinn, Meigs, Rhea, Stewart, Montgomery, Robertson,
Cheatham and Davidson out of State New Hampshire

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 Nu Life Med, LLC Phone Number (603) 206-5725

Street 250 N. Commercial St Suite 3003

City Manchester State NH Zip 03101

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

<u>Patrick Liam Hughes, President</u>	<u>65 Fields Rd,</u>	<u>Portsmouth NH 03801</u>
<u>Michael Avestro, CFO</u>	<u>2 Constitution Court</u>	<u>Freehold, NJ 07728</u>
Name	Street	City, State, Zip

<u>Kacey Wunsch, EVP</u>	<u>11113 Fairfax Station Rd</u>	<u>Fairfax Station, VA 22039</u>
Name	Street	City, State, Zip

<u>Nathalie Soucy, EVP Operations</u>	<u>8 Foxtrail Lane, Unit 5</u>	<u>Goffstown, NH 03045</u>
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 X

f. If no to e., who has said authority? N/A - not a government/county owned facility

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 11/21/2027

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).

NEW HAMPSHIRE
STATE OF ~~TENNESSEE~~

County of ROCKINGHAM

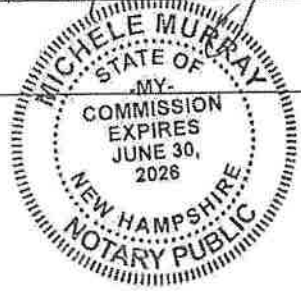
The above named applicant (print name) Michelle DeStefano, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this 2nd day of October 2025
(Month) (Year)

Notary Public: Michelle Murray

My commission expires: _____

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



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.

Michelle Destefano
Applicant Signature

Technical Director of Operations
Title or Position

10/2/2025
Date



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 24, 2026

Sent Via Email

Michelle DeStefano
Nu Life Med, LLC
510 North State Road, Suite 100-02
Briarcliff, New York 10510

Facility Type: Home Medical Equipment

Dear Michelle DeStefano:

It is my pleasure to inform you that your application for licensure of Nu Life Med, LLC located at 510 North State Road, Suite 100-02, Briarcliff, New York 10510 has been initially approved for Out of State of Tennessee provider serving all counties of Tennessee effective April 24, 2026 . The license number shall be 1542 . 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): #1542 County: Out of State

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

Facility Name: Nu Life Med., LLC

Address: 250 Commercial St., Suite 3003 City: Manchester, NH Zip Code: 03101

Application and fee on file in Central Office (CO)? Yes 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 *CS* Date: 4/17/26

Fire Safety: _____ Date: _____

CD Approved: Yes _____ No N/A Health Survey Required: Yes 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 24, 2026 Licensure is recommended: Yes No _____
(Completed by Central Office Licensure Staff)

Kel Rhonda H. Rogers 4/21/2026
Regional Administrator/Facilities Construction Director or Designee Date

Nancy 4/24/26
Licensure Program Unit Staff Date

Administrator is Michelle Destefano: Mstock@nulifemed.net

Certificate of Accreditation Exemplary Provider® Award

Granted To

NuLife Med, LLC


250 N Commercial St Ste 3003 Manchester, NH 03101

for demonstrating
Outstanding Healthcare Delivery Practices
and
Compliance to
Safety ♦ Honesty ♦ Caring®
Accreditation Quality Standards

DMEPOS

EXPIRATION DATE: NOVEMBER 21, 2027

October 21, 2024


Founder & CEO, The Compliance Team, Inc.

036079

Date

DMEPOS
PHARMACY
RURAL HEALTH
PATIENT-CENTERED
MEDICAL HOME
CLINIC
PHYSICIAN
INFUSION
OCULARIST



The Promise of
HEALTHCARE
EXCELLENCE