



Received 3/11/26
E-1568
WTR0 / 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 Prentke Romich Company d/b/a PRC-Salttillo

Location of the Facility:

Street 1022 Heyl Rd City Wooster

County Wayne State Ohio Zip 44691-9786

Phone Number (330) 262-1984 X1230 Fax Number (330) 202-5840

Twenty-four (24) Hour Emergency Phone Number (N/A) 330-262-1984 ext 1230

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (N/A) 330-262-1984 ext 1230

E-Mail Address contracts@prc-salttillo.com

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

Administrator Information:

Administrator Crystal R. Martin

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

Street _____

City _____ State _____ Zip _____

Ownership of Building: We own our building

Name Prentke Romich Company d/b/a PRC-Salttillo Phone Number (330) 262-1984 X1230

Street 1022 Heyl Rd

City Wooster State Ohio Zip 44691 +9786

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

Out of State OHIO, and All Counties in Tennessee

2. Number of branch offices: Zero

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.** *see attached letter

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

Individual Partnership Corporation Limited Liability Company
 Church Related Government/County Other S-Corp

b. Check one: For Profit Non-profit

c. Legal Entity checked in 1.a:

Name Prentke Romich Company d/b/a PRC-Salttillo Phone Number (330) 262-1984
Street 1022 Heyl Rd
City Wooster State Ohio Zip 44691 +9786

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

Employee stockholder ownership program	1022 Heyl Rd	Wooster, OH, 44691
Name	Street	City, State, Zip
<u>Sarah B. Wilds CEO</u>	<u>1614 Sandalwood Drive</u>	<u>Wooster OH 44691</u>
Name	Street	City, State, Zip
<u>Amy L. Miller CFO</u>	<u>5664 Fairland Rd</u>	<u>New Franklin OH 44216</u>
Name	Street	City, State, Zip

(If additional space is needed, please use a separate sheet) See attachment

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, CARF, etc.? **Provide proof of accreditation.**

Yes ACHC No Expiration Date 04/14/2027

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

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 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

Contract Specialist II
Title or Position

03/04/2026
Date

STATE OF ~~TENNESSEE~~ OHIO

County of Wayne

The above named applicant (print name) Crystal Martin, 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 4th day of March 2020
(Month) (Year)



SANDRA M SCHLEIFER
ATTORNEY AT LAW
NOTARY PUBLIC
STATE OF OHIO
My Comm. Has No
Expiration Date
Section 147.03 R. C.

Notary Public: Sandra Schleifer

My commission expires: My comm. has no expiration

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 24, 2026

Sent Via Email

Crystal R Martin
Prentke Romich Company d/b/a PRC-Salttillo
1022 Heyl Rd
Wooster, Ohio 44691

Facility Type: Home Medical Equipment

Dear Crystal Martin:

It is my pleasure to inform you that your application for licensure of Prentke Romich Company d/b/a/ PRC-Salttillo located at 1022 Heyl Rd, Wooster, Ohio 44691 has been initially approved for all counties of Tennessee effective April 24, 2026 . The license number shall be 1568. 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): #1568 County: Out of State

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

Facility Name: PRC-Salttillo

Address: 1022 Heyl Road City: Wooster, Oh Zip Code: 44691

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 *ms* Date: 4/14/26

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
(NOTE: With exception of Initial Licensure Approvals)

Effective date: April 24, 2026 Licensure is recommended: Yes No _____
(Completed by Central Office Licensure Staff)

KZ / Rhonda J. Rogers 4/16/2026
Regional Administrator/Facilities Construction Director or Designee Date

Nancy 4/24/26
Licensure Program Unit Staff Date

Administrator is Crystal Martin: Crystal.Martin@prc-salttillo.com
Please send copy to Sandy Schleifer: Sandy.Schleifer@prc-salttillo.com

CERTIFICATE of ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

Prentke Romich Company
d/b/a PRC-Saltillo
WOOSTER, OHIO


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 #85938

FROM April 15, 2024, THROUGH April 14, 2027




PRESIDENT & CHIEF EXECUTIVE OFFICER

Roy J. Chew
CHAIR OF THE BOARD OF COMMISSIONERS