F-1556
APP# 23854
ETRO|7780

JAN 0 9 2026

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 Reliable Respiratory, Inc.

Location of the Facility:

Street 1502 Providence Turnpike, Ste 10 City Norwood

County Norfolk State MA Zip 02062

Phone Number (781)551-3335 Fax Number (781)987-8206

Twenty-four (24) Hour Emergency Phone Number (781)551-3335

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (781) 551-3335

E-Mail Address ap@reliablerespiratory.com

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

Administrator Information:

Administrator Michael Falkson

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 (NS)

Street ______

City ______ State ______ Zip ______

Ownership of Building:

Name Norwood 5 Star Investments, LLC Phone Number (781)551-3335

Street 1502 Providence Turnpike, Ste 10

City Norwood State MA Zip 02062

1. Are you a provider providing manufactured or distributing company-branded Insulin Infusion Pumps and related supplies? Yes_____ No X_____ *(If so, the following are requirements, which must be met).*

   a. ***Do you have an employee presence within the state of Tennessee?*** *Yes*_____ *No* X (NS)
   (Please describe the nature of the employee's physical presence in the state)_______________

   b. ***Provide Joint Commission Accreditation (JCAHO). (Please provide JCAHO letter and complete report in accordance with T.C.A. TCA 68-11-226(e))***

2. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*
   All counties within the state.

3. Number of branch offices: ~~17~~ 0 (NS)

   Address of each branch office: *(If additional space is needed, please use a separate page)*
   ~~See attached.~~ (NS)

4. **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 X Corporation _____Limited Liability Company

   _____Church Related _____Government/County _____Other

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

   c. Legal Entity checked in 1.a:

   Name Reliable Respiratory, Inc. Phone Number (781) 551-3335

   Street 1502 Providence Turnpike, Ste 10

   City Norwood State MA Zip 02062

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

   M Michael Falkson- 1502 Providence Turnpike Norwood, MA 02062 , MA 02062 (NS)
   ~~See attached.~~

   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 _____ N/A

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 8/31/2027 __________

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. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state? Yes _____ No x ____
b. If yes, where? __________ When? __________
c. For what reason? __________

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.

Michael Falkson — Applicant Signature | Ceo — Title or Position | 9/16/25 — Date

STATE OF ~~TENNESSEE~~ MASSACHUSETTS

County of Norfolk

The above named applicant (print name) Michael Falkson, 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 16th day of September (Month) 2025 (Year)

ERIC LEVITT
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
My Comm. Expires August 6, 2032

Notary Public: E Levitt

My commission expires: 8/6/2032

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

March 9, 2026 Sent Via Email

Michael Falkson
Reliable Respiratory, Inc
1502 Providence Turnpike Ste 10
Norwood, Massachusetts 02062

Facility Type: Home Medical Equipment

Dear Michael Falkson:

It is my pleasure to inform you that your application for licensure of Reliable Respiratory, Inc located at 1502 Providence Turnpike Ste 10, Norwood, Massachusetts 02062 has been initially approved for providing DME/HME services in all counties in Tennessee effective March 9, 2026 . The license number shall be 1556. 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 April 22, 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 East Tennessee Regional Office phone number is 865-594-9396 .

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): _____1556________County: Norfolk

Initial ______X______ Renovation __________ Satellite/Off Campus Location _________

Physical Plant/Services/New Addition _________ Relocation/Replacement Facility________

(Circle One) **(Circle One)**

Facility Name: Reliable Respiratory Inc. 1502 Providence Turnpike, Suite 10 Norwood MA 02062

Application and fee on file in Central Office (CO)? Yes __X__ No __ CON #: ___Project #: __Phase: _____ of __

Facility approved for Home Medical Equipment (HME): Providing DME/HME services in all counties in Tennessee.

Sprinklered: __________________(Full 100%) Partial: _______________(%)

Licensed bed count from: ________0 to ____0___ Number of beds increased/decreased: ______0______________

If secured unit, number of beds in unit: ____N/A_____ 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:________Nancy Mullins RN____________________________ Date: __02/27/26_______

Fire Safety: See attached application______________________________________ Date: _________________

CD Approved: Yes ____ No___ N/A _x____ Health Survey Required: Yes__X__ No ____; if Yes, please indicate which region: ___EAST________________

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Facility's Letter of Notification received in Licensure: Yes __X____ 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: March 9, 2026 Licensure is recommended: Yes __X__ No ____
(Completed by Central Office Licensure Staff)

_______Tom A. Lane, RN, BS/JL_____________________ 03/05/2026__
Regional Administrator/Facilities Construction Director or Designee Date

Niraj Soni 3/9/2026
Licensure Program Unit Staff Date

Reliable Respiratory, Inc.

Norwood, MA

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

August 31, 2024

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #617401
Print/Reprint Date: 09/25/2024

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Wolters Kluwer

C T Corporation

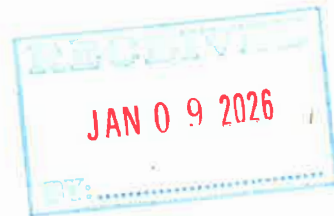
140 Grand Street, Suite 300
White Plains, NY 10601

Phone (800) 292-0909
Fax (212) 672-1105

www.wolterskluwer.com

December 17, 2025

State of Tennessee
502 Deaderick Street
Nashville, TN 37243



Re: **Reliable Respiratory, Inc.**

Dear Sir or Madam,

Enclosed please find the following, being submitted on behalf of our above-referenced client:

Application for Initial Licensure

Once the application has been processed, please forward evidence of approval to the mailing address on the application. If there is any issue, or if you require any further information, please do not hesitate to contact us.

Yours sincerely,

C T Corporation, Business License Unit