WTRO/ITSD
App # 23678
File-1536

RECEIVED
By Niraj Soni at 4:31 pm, Sep 10, 2025

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 180 Medical, Inc

Location of the Facility:

Street 10707 Mockingbird Drive City Omaha

County Douglas State NE Zip 68127

Phone Number ( ) (402) 315-3756 Fax Number (888) 718-0633

Twenty-four (24) Hour Emergency Phone Number (877-688-2729 CNS) CNS)

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (877-688-2729

E-Mail Address 180-Accreditation@180medical.com CNS)

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

Administrator Information:

Administrator Jeffery Hendrix

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

Mailing address if different from the Facility location address:

Name 180 Medical, Inc Attn: Sara Munoz CNS)

Street 8516 NW Expressway

City Oklahoma City State OK Zip 73162

Ownership of Building:

Name 10701 Mockingbird Street, LLC Phone Number (402-702-2712 CNS)

Street 3219 Laveanworth Street

City Omaha State NE Zip 68105

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

All counties of Tennessee (CNS), out of State Nebraska (CNS)

2. Number of branch offices: 0 (CNS)

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 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 180 Medical Acquisition, Inc Phone Number (877) 688-2729

Street 8516 NW Expressway

City Oklahoma City State OK Zip 73162

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
Mark Jassey	524 NW 16th St	Oklahoma City, OK 73103
Jeffery Hendrix	9008 NW 148th Pl	Yukon, OK 73099
John Holtz	5714 Reef Landing Way	Wilmington, NC 28409

(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. 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 [illegible] 10/12/2028

10/12/2028 (NS)

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

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 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.

X 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 Title or Position	8/26/2025 Date

(NS)

STATE OF ~~TENNESSEE~~ Oklahoma

County of Cleveland

The above named applicant (print name) Jeffrey Hendrix, 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 26th day of August (Month) 2025 (Year)

Notary Public: [signature]

My commission expires: 09/30/2028

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

CHRISTINA A. ROSE NOTARY PUBLIC #20012012 EXP. 09/30/2028 STATE OF OKLAHOMA

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

February 19, 2026 Sent Via Email

Jeffrey Hendrix
180 Medical, Inc
10707 Mockingbird Drive
Omaha, Nebraska 68127

Facility Type: Home Medical Equipment

Dear Jeffrey Hendrix:

It is my pleasure to inform you that your application for licensure of 180 Medical, Inc located at 10707 Mockingbird Drive, Omaha, NE 68127 has been initially approved for Out of State HME providing services to all counties in Tennessee effective February 19, 2026 . The license number shall be 1536 . 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 March 25,2026 . **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): #1536 County: Out of State HME provider

Initial Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: 180 Medical Inc.

Address: 10707 Mockingbird Drive City: Omaha, NE ZIP 5919 Code: 68127

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): Approved for Out of State HME providing services to all counties of TN

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 Date: 12/23/25

Fire Safety: _____ Date: __

CD Approved: Yes____ No ____ N/A X Health Survey Required: Yes: X No____

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 X
(NOTE: With exception of Initial Licensure Approvals)

Effective date: February 19, 2026 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

KZL Amanda D Rogers 1/8/2026
Regional Administrator/Facilities Construction Director or Designee Date

Licensure Program Unit Staff 2/19/26
Date

Administrator is Jeffrey Hendrix:180-accreditation@180medical.com
Please Send copy to Amanda Brakebill: Amandabrakebill@180medical.com

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

180 Medical, Inc.

OMAHA, NEBRASKA

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

Medical Supply Provider Services

Accreditation #49221

FROM *October 13, 2025,* THROUGH *October 12, 2028*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIR OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC