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

May 22, 2026 Sent Via Email

Emmy Sparks
Convacare Services
2599 W. Fountain Dr.
Bloomington, Indiana 47404

Facility Type: Home Medical Equipment

Dear Emmy Sparks:

It is my pleasure to inform you that your application for licensure of Convacare Services Inc. located at 2599 W. Fountain Dr, Bloomington, Indiana 47404 has been initially approved for providing DME/HME services in all counties of Tennessee effective May 22, 2026 . The license number shall be 1570 . 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 June 24, 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

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1570 County: Monroe

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Convacare Services 2599 W. Fountain Dr. Bloomington In. 47404

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: 05/11/26

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

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 ____ N/A
(NOTE: With exception of Initial Licensure Approvals)

Effective date: MAY 22, 2026 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

Don A. Rane RN, JD 5/21/2026
Regional Administrator/Facilities Construction Director or Designee Date

Licensure Program Unit Staff 5/22/26
Date

Application Summary

Application Detail

License Type:	**Home Medical Equipment: Licensed**
Application:	**Home Medical Equipment: Initial Application**
Application Date:	**03/30/2026 (mm/dd/yyyy)**

Organization Detail

Organization Name:	**Convacare Services Inc.**
Organization type: Corporation	

Addresses

Main Address

Address:	**2599 W. Fountain Dr**
	MONROE
	Bloomington, IN
	47404
	US
Phone Number:	**812-323-2170**
Extension:	
E-mail Address:	**licensing@lincare.com**

Administrative

Name:	**Lincare, Inc.**
Address:	**19387 US Highway 19 North**
	Attn: Licensing Department
	PINELLAS
	Clearwater, FL
	33764
	US
Phone Number:	**727-530-7700**
Extension:	
E-mail Address:	**licensing@lincare.com**

Emergency Contact

Name:	**Convacare Services Inc.**
Address:	**2599 W. Fountain Dr** **MONROE** **Bloomington, IN** **47404** **US**
Phone Number:	**812-323-2170**
Extension:	
E-mail Address:	**licensing@lincare.com**

Ownership of Building

Name:	**Busted Block LLC**
Address:	**1100 S. Strong Dr** **Attn: Warren Cutshall** **MONROE** **Bloomington, IN** **47403** **US**
Phone Number:	**812-323-2170**
Extension:	
E-mail Address:	**licensing@lincare.com**

Legal Entity

Name:	**Convacare Services Inc.**
Address:	**2599 W. Fountain Dr** **MONROE** **Bloomington, IN** **47404** **US**

Phone Number:	**812-323-2170**
Extension:	
E-mail Address:	**licensing@lincare.com**

License Attributes Selected

Qualification/Certification	**All Counties**
	Out of State Indiana
Additional License Information	**For Profit**

Basic License Data

If your facility has branch offices provide the number. If none, enter 00	**00**
Provide Administrator's Name:	**Emmy Sparks**
Provide the Ownership's Name:	**Convacare Services Inc.**
Is your facility accredited by a federally approved accrediting body?	**Yes**
If answered yes accredited, must provide expiration date of accreditation.	**12/15/2027 (mm/dd/yyyy)**
What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?	**Free Standing**
Provide a Yes or No, if your facility is Chain Affiliated:	**Yes**
Provide a Yes or No, if your facility has a Holding Company:	**No**
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	**Yes**
Provide a Yes or No, if your facility has a parent company:	**Yes**
Do you have a contract with a management firm to operate this facility?	**No**
Have any owners 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?	**No**

Have any owners 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?	
Does your facility have a physical location in Tennessee?:	**No**

Administrator Conviction Information

Administrator convicted of crime?:	**No**

Individual Owners, Partners, Director or Head of Government Entity 1

The name of the individual owner, partner, director of the corporation or head of the government:	**Jeffrey Barnhard, CEO**
Street:	**19387 US Highway 19 N**
City:	**Clearwater**
State:	**Florida**
Zip:	**33764**

Individual Owners, Partners, Director or Head of Government Entity 2

The name of the individual owner, partner, director of the corporation or head of the government:	**Carlos Paiva, CFO**
Street:	**19387 US Highway 19 N**
City:	**Clearwater**
State:	**Florida**
Zip:	**33764**

Individual Owners, Partners, Director or Head of Government Entity 3

The name of the individual owner, partner, director of the corporation or head of the government:	**Andrew Sarantapoulas, VP of Business Process Improvement**
Street:	**19387 US Highway 19 N**
City:	**Clearwater**
State:	**Florida**
Zip:	**33764**

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended	**No**

or revoked?:

Have any of owners of the disclosing entity had a suspension of admissions?:	**No**
Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state?:	**No**

File Attachments

Convacare CHAP + Statements.pdf

Fees

Initial License Fee	**$1404.00**
Total Amount Due:	**$1404.00**

Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Home Medical Equipment facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Home Medical Equipment facility. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

CHAP Community Health Accreditation Partner

Certificate of Accreditation

This is to certify that the following organization has met the requirements of the Community Health Accreditation Partner (CHAP) Standards of Excellence, and demonstrated a commitment to providing quality patient care and services.

CONVACARE SERVICES, INC

is therefore granted accreditation for the following:

Home Medical Equipment

Effective: 12/15/2024

Expiration: 12/15/2027

Nathan J. DeGodt
President and CEO, CHAP

COMMUNITY HEALTH ACCREDITATION PARTNER
CHAP
EST. 1965
SEAL OF ACCREDITATION

Patricia Driscoll
Chair, CHAP Board of Directors

CHAP is an independent, nonprofit accrediting body for organizations providing home and community-based health care services in accordance with nationally recognized CHAP Standards of Excellence. Additional information regarding CHAP Accreditation and a listing of individual accredited organizations can be obtained by visiting www.CHAPinc.org.

Customer ID: 2001083