

Application Detail

License Type: Home Medical Equipment: Licensed
Application: Home Medical Equipment: Initial Application
Application Date: 10/20/2025 (mm/dd/yyyy)

Organization Detail

Organization Name: HOME OXYGEN COMPANY INC
Organization Type Corporation

Addresses

Main Address

Address: 5039 PENTECOST DR
STE C
STANISLAUS
Modesto, CA
95356
US
Phone Number: 877-799-0202
Extension:
E-mail Address: andrea@homeoxygencompany.com

Administrative

Name: HOME OXYGEN COMPANY INC
Address: 5039 PENTECOST DR
STE C
STANISLAUS
Modesto, CA
95356
US
Phone Number: 877-799-0202
Extension:

E-mail Address:

andrea@homeoxygencompany.com

Emergency Contact

Name:

HOME OXYGEN COMPANY INC

Address:

5039 PENTECOST DR

STE C

STANISLAUS

Modesto, CA

95356

US

Phone Number:

877-799-0202

Extension:

E-mail Address:

andrea@homeoxygencompany.com

Ownership of Building

Name:

HOME OXYGEN COMPANY INC

Address:

1265 CUMMINS DR

STANISLAUS

Modesto, CA

95358

US

Phone Number:

209-523-2674

Extension:

E-mail Address:

phil@acmeconstruction.com

Legal Entity

Name:

HOME OXYGEN COMPANY INC

Address:

5039 PENTECOST DR

STE C

STANISLAUS

Modesto, CA

95356

US

Phone Number:

877-799-0202

Extension:

E-mail Address:

andrea@homeoxygencompany.com

License Attributes Selected

Qualification/Certification

Out of State California

Additional License Information

For Profit

All counties of Tennessee

Basic License Data

If your facility has branch offices provide the number. If none, enter 00

00

Provide Administrator's Name:

ANDREA EWERT

Provide the Ownership's Name:

HOME OXYGEN COMPANY INC

Is your facility accredited by a federally approved accrediting body?

Yes

If answered yes accredited, must provide expiration date of accreditation.

02/28/2027 (mm/dd/yyyy)

What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?

Free Standing HME (NS)

Provide a Yes or No, if your facility is Chain Affiliated:

No

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?

No

Provide a Yes or No, if your facility has a parent company:

No

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

No

civil monetary 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

The name of the individual owner, partner, director of the corporation or head of the government: **ANDREA EWERT**

Street: **3021 NOTTINGHAM LN**

City: **MODESTO**

State: **California**

Zip: **95350**

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?: **No**

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

Liability Insurance with PL.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.

Board of Certification/Accreditation

Chilings Mills, Maryland

Accredited Facility

Practice limited to DMEPOS supplier categories:
DM02, DM03, DM07, DM09, DM10, DM20, DM22, DM26, M01, M02, M03, M05, M06, M06A, M07, M07A
M10, PD08, PD09, PE03, PE04, R01, R02, R04, R05, R06, R07, R08, R08A, R09, R10, R12

The Board of Certification/Accreditation attests that the Facility named below complies with all requirements for facility accreditation.

Home Oxygen Company, Inc.
5039 Pentecost Dr Ste C
Modesto, California 95356-9290

This accreditation is awarded for meeting the professional standards of BOC, together with all the honors, rights, privileges and responsibilities in pursuit of our mission to assure patients, physicians, professional organizations, the public-at-large, and government agencies and representatives of the competence and professionalism of BOC Accredited Facilities. In witness whereof, we have affixed the seal of the Board and subscribe our names in acknowledgment.



Matthew Gruska, MBA, BOCC, BOCPD, CDIME, Chief Operating Officer



Judi L. Knott, MA, MBA, President & CEO

S01999

Facility Number

February 28, 2027

Accredited Through

Accredited Since February 11, 2009



BOC is a CMS deemed accrediting organization.

This accreditation is the property of BOC — the certificate holder agrees to abide by the BOC and CMS standards.



State of Tennessee
Health Facilities Commission
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

December 19, 2025

Sent Via Email

Andrea Ewert
Home Oxygen Company Inc
5039 Pentecost Dr, STE C
Modesto, California 95356

Facility Type: Home Medical Equipment

Dear Andrea Ewert:

It is my pleasure to inform you that your application for licensure of Home Oxygen Company, Inc located at 5039 Pentecost Dr, Ste C Modesto, California 95356 has been initially approved for providing DME/HME services in all counties in Tennessee effective December 19, 2025 . The license number shall be 1543. 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 January 28, 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

cc: East Tennessee Regional Office



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1543 County: Stanislaus

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

Facility Name: Home Oxygen Company

Address: 5039 Pentecost Drive Suite C City: Modesto California Zip Code: 95356

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): 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: 12/15/25

Fire Safety: See attached application Date: _____

CD Approved: Yes _____ No _____ N/A Health Survey Required: Yes No _____; if Yes, please indicate which region: EAST

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

Effective date: December Licensure is recommended: Yes No
(Completed by Central Office Licensure Staff)

[Signature] 12/17/2025
Regional Administrator/Facilities Construction Director or Designee Date
[Signature] 12/19/25
Licensure Program Unit Staff Date