



State of Tennessee  
Health Facilities Commission  
665 Mainstream Drive, 2<sup>nd</sup> Floor, Nashville, TN 37243  
[www.tn.gov/hfc](http://www.tn.gov/hfc) Phone: 615-741-7221

July 2, 2025

Sent Via Email

Rita Cohen  
Atomic Care Home Health, LLC  
99905 Brannigan Circle  
Knoxville, Tennessee 37923

Facility Type: Home Health Agencies

Dear Rita Cohen:

It is my pleasure to inform you that your application for licensure of Atomic Care Home Health, LLC located at 9905 Brannigan Circle, Knoxville, TN 37923 has been initially approved July, 1 2025. The license number shall be 702. 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 July 23, 2025. **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 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,

*Angela Tyler*

Angela Tyler

cc: East Tennessee Regional Office



TNHL 289

### APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: Home Health EEO/CPA License # (if applicable): \_\_\_\_\_ County: Knox

Initial X Renovation \_\_\_\_\_ Satellite/Off Campus Location \_\_\_\_\_

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

Facility Name: Atomic Care Home Health LLC

Address: 9905 Brannigan Circle City: Knoxville TN Zip Code: \_\_\_\_\_

Application and fee on file in Central Office (CO)? Yes ☒ No \_\_\_\_\_ CON #: \_\_\_\_\_

Project #: NA Phase: \_\_\_\_\_ of \_\_\_\_\_

Facility approved for (if satellite/off campus site include address): SN, HHA Homemaker  
Anderson, Roane, Campbell, Knox, Loudon  
Monroe, Blount, Sevier, Morgan

Sprinklered: NA (Full 100%) Partial: NA (%)

Licensed bed count from: \_\_\_\_\_ to \_\_\_\_\_ Number of beds increased/decreased: \_\_\_\_\_

If secured unit, number of beds in unit: NA 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: Jessie  
NA

Date: 6/30/2025

Fire Safety: \_\_\_\_\_

Date: \_\_\_\_\_

CD Approved: Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Health Survey Required: Yes ☒ No \_\_\_\_\_

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: 7-1-2025  
(Completed by Central Office Licensure Staff)

Licensure is recommended: Yes ☒ No \_\_\_\_\_

Dr. Divya Verna

6/30/2025

Regional Administrator/Facilities Construction Director or Designee

Date

[Signature]

Date



**State of Tennessee**

**Health Facilities Commission**

665 Mainstream Drive, 2<sup>nd</sup> Floor, Nashville, TN 37243

[www.tn.gov/hfc](http://www.tn.gov/hfc)

Phone: 615-741-7221

May 27, 2025

Sent Via Email

Rita Cohan  
Atomic Care Home Health, LLC  
9905 Brannigan Circle  
Knoxville, Tennessee 37923

Dear Rita Cohan

This is to acknowledge receipt of your application and fee to apply for licensure of Atomic Care Home Health, LLC. Please review the instruction sheet that you received with the application to apply for licensure so that you are aware of the process for obtaining licensure of your facility. If a certificate of need is required to provide services, you will need to contact Health Facilities Commission at (615) 741-2364.

Please remember that if you are applying for licensure of a facility that requires architectural plan review contact Plans Review for complete and details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey. **For Homes for the Aged facilities specifically, TCA-368-11-202 allows "schematics shall be submitted to the department for approval of plans and specifications, converting and existing single-family dwelling" with six (6) or less beds.**

It is your responsibility to contact the East Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to East Tennessee Regional Administrator, 7175 Strawberry Plains Pike Suite 103, Knoxville, Tennessee 37914. If you would like to fax the request to Debra Verna the fax number is 864-594-5739.

Your application and fee will be held in a pending status until you are recommended by the East Tennessee Regional Office for licensure. Once the recommendation for licensure is received from the regional office, your facility will receive a letter for "Initial Approval." Admission of patients MAY NOT occur until the facility's receipt of the "Initial Approval" letter. Your application will be presented before the Board for Licensing Health Facilities Commission for ratification and final approval at the next regularly scheduled commission meeting. Your facility can operate once you receive the "Initial Approval."

This application will only be good for one (1) year from the date of receipt. If the initial licensure has not occurred within that one (1) year period, you will be required to submit a new application and fee unless you have contacted our office in writing extending your application.

If a certificate of need is required prior to obtaining a license for this facility the application file will be closed the day following the expiration date of the certificate of need.

Should you have any questions or if I can be of assistance to you, please call me at (615) 741-7221 or you may email me at [Angela.A.Tyler@tn.gov](mailto:Angela.A.Tyler@tn.gov).

Sincerely,

*Angela Tyler*

Angela Tyler



ETRO / File # 702  
ISTD / APPH 13085



## HOME HEALTH SERVICES 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 Atomic Care Home Health LLC

Location of the Facility:

Street 9905 Brannigan Circle City Knoxville

County Knox State Tennessee Zip 37923

Phone Number ( ) 865-606-1212 Fax Number 423-205-2441

Twenty-four (24) Hour Emergency Phone 865-606-1212

Number ( E-Mail Address atomiccarehealth@gmail.com

Administrator Information:

Administrator Rita Cohan Rita Cohan

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, 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 \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ownership of Building:

Name Rita Cohan Phone Number 865-617-1595

Street 9905 Brannigan Circle

City Knoxville State Tennessee Zip 37923

1. Check type: Hospital Based \_\_\_\_\_ Nursing Home Based \_\_\_\_\_ Free Standing X

2. Check type: Licensed only Agency X Licensed/Medicaid Certified \_\_\_\_\_

3. Check type of services provided:

- |                                     |  |
|-------------------------------------|--|
| a. b. c. d. e. Medical Social _____ | f. Home Health Aid Services _____ <u>X</u> |
| Services Skilled Nursing <u>X</u> ✓ | g. Medical Supplies and Appliances _____   |
| Physical Therapy _____              | h. Homemaker Services _____ <u>X</u>       |
| Occupational Therapy _____          | i. Other (please specify) _____            |
| Speech Therapy _____                |  |

4. Do you have a Certificate of Need (CON)? Yes \_\_\_\_\_ No X

If yes, what is the geographic area served by the Agency: (list county or counties) If additional space is needed, please use a separate page.

\_\_\_\_\_

\_\_\_\_\_

5. Do you provide services to a pediatric population? Yes \_\_\_\_\_ No X

If yes, what counties? \_\_\_\_\_

6. Is your agency a provider in the EEOICPA federal program? Yes X No \_\_\_\_\_

If yes, what counties? Anderson, Roane, Campbell, Knox, Loudon, Monroe, Blount, Sevier,

7. Provide proof of the ability to meet the financial needs of the facility. Morgan

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

Individual \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_ Limited Liability Company X  
Church Related \_\_\_\_\_ Government/County \_\_\_\_\_ Other \_\_\_\_\_

b. Check one: For Profit X Non-profit \_\_\_\_\_

c. Legal Entity checked in 1.a:

Name Atomic Care Home Health LLC Phone Number 865-606-1212  
Address 9905 Brannigan Circle Knoxville, TN 37923

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

<u>Rita Cohan</u>	<u>9905 Brannigan Circle Knoxville, TN 37923</u>
Name _____	Street <u>field</u> City, State, Zip _____
<u>Haley Heacock</u>	<u>7114 Sheffield Drive Knoxville, TN 37909</u>
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 X

f. If no to e., who has said authority? Rita Cohan, RN

2. a. Is your facility/organization accredited by a federally approved accrediting body including but not limited to JCAHO, CARF, etc.? Provide proof of accreditation.

\_\_\_\_\_

Yes \_\_\_\_\_ No X Expiration Date \_\_\_\_\_

3. Is this facility chain affiliated? Yes \_\_\_\_\_ No X

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

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_

5. 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 \_\_\_\_\_

6. a. Are any owners of the disclosing entity 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:

\_\_\_\_\_

\_\_\_\_\_

7. 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 \_\_\_\_\_

8. For any item in (8) 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 (6.b.) above, OR the management firm listed in question (7.) 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 8(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.

Rita Cohan Registered Nurse 5-5-2025  
Applicant Signature Title or Position Date

STATE OF TENNESSEE

County of Knox

~~The~~ Above named applicant (print name) Rita Cohan,

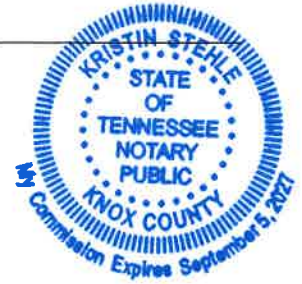
by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this 5 day of May (Month) 2025 (Year)

Notary Public: Kristin Stehle

My commission expires: 09/05/2027

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





\*\*\*\* DUPLICATE \*\*\*\*



STATE OF TENNESSEE  
Health Services and Dev Agency  
Office: Andrew Jackson, 8t  
5/6/2025 11:45 AM

Cashier: NIRAB0824001  
Batch #: 1695055  
Trans #: 3

Receipt #:	Licensure	
HA15	40322585	
Application and Rene		\$1,404.00
Payment Total:		\$1,404.00
Transaction Total:		\$1,404.00
Check 21		\$1,404.00

Thank you for your payment.  
Have a nice day!

\*\*\*\* DUPLICATE \*\*\*\*

File #702

App #13085

Rita Vanesia Cohan 9905 Brannigan Circle Knoxville, TN 37923	5-5 2025	1191 87-6139/2642
Pay to the order of	State of TN Treasury	\$1404.00
PUPPY LOVE	One thousand, four hundred, four	Dollars
Tennessee Members 1st FCU Oak Ridge, TN 37831		Security Features Details on Back



Tennessee Department of Health  
Cash Listing Report

Client: 343 - DEPARTMENT OF HEALTH

Batch #: 882

Total \$ Entered: \$ 1,404.00

Origin: Deposit

Deposit #: 05062025

Fiscal Year: 2025

Deposit Date: 2025-05-27

# Receipt: 1

Receipts Entered: 1

Total: \$ 1,404.00

Status: Deposited

Receipt #	DLN	Received	Disp	Pmt	Bad Check?	Unsigned	Prof	Remitted By / Beneficiary	File #	License #	As
1971	40322585	\$ 1,404.00	DEP	CHK		\$ 1,404.00	534	ATOMIC CARE HOME HELATH,LLC	702		
Total:		\$ 1,404.00				\$ 1,404.00					



**Tre Hargett**  
Secretary of State

**Division of Business and Charitable Organizations**  
**Department of State**  
State of Tennessee  
312 Rosa L. Parks Avenue, 6th Floor  
Nashville, Tennessee 37243  
Phone: 615-741-2286  
sos.tn.gov/

ERIK TREUTLEIN  
11501 Domain Dr., Ste. 200  
Austin, TX 78758, USA

04/30/2025

## Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Entity Name:	ATOMIC CARE HOME HEALTH LLC		
SOS Control #:	002018106	Initial Filing Date:	04/30/2025
Entity Type:	Limited Liability Company (LLC)	Formation Locale:	TENNESSEE
Status:	Active	Duration Term:	Perpetual
Fiscal Year Close:	December	Annual Report Due:	04/01/2026
Business County:	Knox		
Managed By:	Member Managed		
Obligated Member Entity:	No		

### Document Receipt

Receipt #: 2025-318842	Filing Fee:	\$300.00
Payment: Credit Card - 3897437223		\$300.00

**Registered Agent Address:**  
UNITED STATES CORPORATION AGENTS, INC.  
5865 RIDGEWAY CENTER PKWY STE 384  
MEMPHIS, TN 38120-4032

**Principal Office Address:**  
9905 Brannigan Cir  
Knoxville, TN 37923  
Knox County, USA

Congratulations on the successful filing of your Articles of Organization - Limited Liability Company for **ATOMIC CARE HOME HEALTH LLC** in the State of Tennessee which is effective **04/30/2025**. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website ([www.tn.gov/revenue](http://www.tn.gov/revenue)) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett  
Secretary of State

Tracking Number  
B2025249453



Tre Hargett  
Secretary of State

## Articles Of Organization

Division of Business and Charitable Organizations

Department of State

State of Tennessee

312 Rosa L. Parks Avenue, 6th Floor

Nashville, Tennessee 37243

Phone: 615-741-2286

sos.tn.gov/businesses

Control #: 002018106

Filed: 04/30/2025 12:18 PM

Tre Hargett

Secretary of State

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### Entity Information

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**Entity Name:** ATOMIC CARE HOME HEALTH LLC

**Entity Type:** Limited Liability Company

**Fiscal Year Ending Month:** December

**Additional Designation:** (No additional designation)

**Series LLC ?**

☐ Yes ☒ No

**Principal Office Address**

9905 Brannigan Cir  
Knoxville, TN 37923  
Knox County, USA

**Mailing Address**

9905 Brannigan Cir  
Knoxville, TN 37923  
Knox County, USA

**Period of Duration:**

Perpetual

**Will this filing have a delayed effective date?**

☐ Yes ☒ No

**Nature of Business (NAICS):**

621610 - Home Health Care Services

**Other Provisions:**

(No other provisions)

Do you have additional uploads you would like to attach to this filing?

☐ Yes ☒ No

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### Registered Agent Information

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UNITED STATES CORPORATION AGENTS, INC.  
5865 RIDGEWAY CENTER PKWY STE 384  
MEMPHIS, TN 38120-4032

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### Member Information

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**The Limited Liability Company will be:** Member Managed

**Do you have six or fewer members at the date of this filing?**

☒ Yes ☐ No

**Number of Members at the date of filing:**

**Will this entity be registered as an Obligated Member Entity (OME)**

☐ Yes ☒ No

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## Organizer's Signature

---

☒ By entering my name in the space provided below, I certify that I am authorized to file this document on behalf of this entity, have examined the document and, to the best of my knowledge and belief, it is true, correct and complete as of this day.

☒ The undersigned, acting as organizer of the limited liability company under the provisions of the Tennessee Revised Limited Liability Company Act, adopt the above Articles of Organization.

**Signed Electronically:** HALEY CATHLEEN HEACOCK

**Date:** 04/30/2025



State of Tennessee

Health Facilities Commission

502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243

www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

## INITIAL NOTIFICATION OF HOME HEALTH ACCREDITATION FOR CON EXEMPTION

Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a health care institution or initiates any service specified in T.C.A. 68-11-1607 (a) (3) pursuant to the exemption provided in T.C.A. 68-11-1607 (r) or T.C.A. 68-11-1607 (r). This form must be emailed to [hsda.staff@tn.gov](mailto:hsda.staff@tn.gov).

### 1. REPORTING DATE:

5/8/2025

### 2. CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION

Rita Cohan	President
(Name)	(Title)
Atomic Care Home Health LLC	atomiccarehealth@gmail.com
(Company)	(Email Address)
9905 Brannigan Circle	865-617-1595
(Mailing Address)	(Telephone Number)
Knoxville, TN 37923	423-205-2441
(City) (State) (Zip)	(Fax Number)

### 3. IF SEEKING THE ESTABLISHMENT OF A HOME HEALTH AGENCY UNDER EXEMPTION, DATE OF LICENSE SUBMISSION:

5/5/2025

### 4. IF CURRENTLY LICENSED, PROVIDE LICENSE #:

LIST CURRENT LICENSED COUNTIES:

COUNTIES LICENSED UNDER EEOICPA:

Anderson, Roane, Campbell, Knox, Loudon, Monroe, Blount, Sevier, Morgan

COUNTIES LICENSED UNDER PEDIATRIC



COUNTIES LICENSED AS HOME INFUSION ONLY:

LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:

5. DESCRIPTION OF EXEMPTED ACTIVITY:

EEOICPA Home Health

LIST OF EXEMPTED COUNTIES TO BE ADDED UNDER THE FOLLOWING TYPES:

PEDIATRIC:

EEOICPA:

EEOICPA Home Health

6. NAME AND ADDRESS OF PROVIDER

Atomic Care Home Health LLC

(Name)

9905 Brannigan Circle

(Street Address)

Knoxville, TN 37923

(City) (State) (Zip)

7. ACCREDITATION (must be completed within 2 years of initial licensure)

Please Check

- ☒ Community Health Accreditation Program, Inc. Accreditation Commission for Health Care and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects;
- ☐
- ☐

**I UNDERSTAND THAT A HOME HEALTH AGENCY THAT PROVIDES HOME HEALTH SERVICES WITHOUT A CERTIFICATE OF NEED TO PEDIATRIC AND/OR EEOICPA PATIENTS THAT FAILS TO COMPLY WITH THE ACCREDITATION REQUIREMENTS IS SUBJECT TO LICENSURE SANCTIONS.**



\_\_\_\_\_  
Signature of authorized agent

5/8/2025

\_\_\_\_\_  
Date

Rita Cohan

\_\_\_\_\_  
Printed Name