F-1529
WTRO/FTSD
APPLT 23617

RECEIVED
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BY:

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 Liberator Medical Supply, Inc.

**Location of the Facility:**

Street 1823 SE Airport Road City Stuart

County Martin State FL Zip 34996

Phone Number ( 800 ) 323-0914 Fax Number ( 877 ) 323-0914

Twenty-four (24) Hour Emergency Phone Number ( 800 ) 323-0914

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week ( 800 ) 323-0914

E-Mail Address Contractadmin@Liberatormedical.com

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

**Administrator Information:**

Administrator Robert Emerson

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 Liberator Medical Supply, Inc.

Street P.O. Box 446

City Stuart State FL Zip 34995

**Ownership of Building:**

Name Martin County Phone Number ( 772 ) 288-5400

Street 2011 SE Airport Road

City Stuart State FL Zip 34995

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

2. Number of branch offices: 0

Address of each branch office: *(If additional space is needed, please use a separate page)*
N/A

3. **Provide proof of the ability to meet the financial needs of the facility.** See Attachment A

**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 Liberator Medical Supply, Inc. Phone Number ( 800 ) 323-0914

Street 1823 SE Airport Road

City Stuart State FL Zip 34996

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

See Attachment B

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? N/A

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

Yes X No_____ Expiration Date 11/01/2027

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

Name Liberator Medical Holdings Inc. Phone Number ( 772 ) 287-2414

Address 1823 SE Airport Road, Stuart, FL 34996

4. a. If a corporation, is there a holding company? Yes X No ____

b. If yes, list the name, address and phone number of the holding company:

Name Liberator Medical Holdings Inc. Phone Number ( 772 ) 287-2414

Street 1823 SE Airport Road

City Stuart State FL Zip 34996

5. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes X No ____

b. If yes, list names and addresses of all such facilities:

Tri-County Medical & Ostomy Supplies, Inc.
198 Marketplace Blvd., Suite B110, Johnson City, TN 37604

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: See Attachment D

**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 X No_____

*(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 X lo_____

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.

☑ 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 | Vice President<br>Title or Position | 5/27/25<br>Date |
|---|---|---|

**STATE OF ~~TENNESSEE~~** Florida

County of Martin

The above named applicant (print name) Robert Emerson, 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 27 day of May (Month) 2025 (Year)

Notary Public: [signature]

My commission expires: 6/19/28

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

NOTARY PUBLIC STATE OF FLORIDA
BONNIE K. HAYNES
Commission # HH 494383
Expires June 19, 2028

**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

April 24, 2026 Sent Via Email

Robert Emerson
Liberator Medical Supply, Inc
Po Box 446
Stuart, Florida 34995

Facility Type: Home Medical Equipment

Dear Robert Emerson:

It is my pleasure to inform you that your application for licensure of Liberator Medical Supply located at 1823 SE Airport Road, Stuart, Florida 34996 has been initially approved for Out of State Home Medical Equipment serving all counties in Tennessee effective April 24, 2026 . The license number shall be 1529. 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 May 27, 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): #1529 County: Out of State

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Liberator Medical Supply, Inc.

Address: 1823 SE Airport Rd., City: Stuart, FL. Zip Code: 34996

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): Out of State Home Medical Equipment provider Serving all counties of Tennessee

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: 4/15/26

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A X

Health Survey Required: Yes X No__; if Yes, please indicate which region: WTN

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 NA
**(NOTE: With exception of Initial Licensure Approvals)**

Effective date: April 24, 2026 Licensure is recommended: Yes X No ____
**(Completed by Central Office Licensure Staff)**

KZ Rhonda G. Rogers 4/17/2026
Regional Administrator/Facilities Construction Director or Designee Date

4/24/26
Licensure Program Unit Staff Date

Administrator is Robert Emerson: Robert.emerson@liberatormedical.com
Please send copy to Jennifer Young : Jyoung@liberatormedical.com

# Liberator Medical Supply, Inc.

Stuart, FL

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

November 1, 2024

Accreditation is customarily valid for up to 36 months.

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

ID #518292
Print/Reprint Date: 11/05/2024

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.

**State of Tennessee**

**Health Facilities Commission**

502 Deadrick Street , Andrew Jackson Building # 9th Floor

**www.tn.gov/hsda** Phone: 615-741-7221

April 30, 2026

Health Facilities Commission
502 Deadrick Street 9th Floor Andrew Jackson Building
Nashville, Tennessee 37243

Re: Verification for Tennessee Health Care Facility licensure applicant

Dear Sir or Madam:

**Liberator Supply, LLC** has submitted an application for licensure as a(n) **Home Medical Equipment** to the state of Tennessee, Health Facilities Commission. On this application, **Please see attached listing** indicated licensure as a(n) attachment in your state. This verification form must be completed by your state licensing commission which granted the license and returned to the state of Tennessee, Health Facilities Commission, Licensure and Regulation within ten (10) business days in order for our office to process the licensure application.

This is to verify that Tri- County Medical & Ostomy Supplies Inc.
NAME OF FACILITY/LEGAL ENTITY

1904 Knob Creek Rd. Ste. 1
ADDRESS

Johnson City, TN. 37604
CITY, STATE & ZIP CODE

Was issued license number 548795 on February 19, 2004 in the state of Tennessee

This is to further verify that the above named license is current and in good standing, and that there has/have not been any suspension/disciplinary action imposed against the license. **If so, please provide detail.** (Separate Sheet)

This 4th day of May 2026.

Signature

East TN Regional Administrator
Title

Complete Name of Licensing Agency

## Attachment D

## #7 Response Explanation and Documentation

**7(d) suspended or terminated from participation in Medicare or Medicaid/TennCare programs?**

Liberator Medical Supply, Inc.'s enrollment in the Connecticut Medical Assistance Program was terminated without cause in October 2020 and reinstated upon reapplication in December 2021. Enclosed is a copy of the termination letter and appeal documentation.

**7(e) 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?**

Liberator Medical Supply, Inc. and its affiliates received a Civil Investigative Demand from the US Department of Justice regarding past sales and marketing practices. Liberator Medical Supply, Inc. and its affiliates agreed to pay a $17 million civil settlement to resolve allegations that they violated the False Claims Act. The claims resolved by the settlement are allegations only and there has been no determination of liability. Enclosed is a notification letter from the company and a copy of the Press Release.

**Liberator Medical Supply, Inc.**
2979 SE Gran Park Way
Stuart, FL 34997
Phone: (800) 323-0914
Fax: (877) 730-7796
www.LiberatorMedical.com

Liberator™
Medical Supply

April 15, 2021

Nicole Sinisgalli
Department of Social Services
Office of Quality Assurance
Medical Audit Unit
55 Farmington Avenue
Hartford, CT 06105

RE: Provider Enrollment Denial, ATN: 292519, NPI: 1881698439, AVRS ID: MCD 003111870

Dear Ms. Sinisgalli,

We are in receipt of the letter dated September 8, 2020 from the Department of Social Services' Office of Quality Assurance notifying Liberator Medical Supply, Inc. that our enrollment in the Connecticut Medical Assistance Program has been denied.

Section 1902 of the Social Security Act directs state Medicaid agencies to reimburse providers for any Medicare cost sharing that is due for QMBs according to the state's CMS-approved Medicare cost-sharing payment methodology. State Medicaid Management Information Systems (MMIS) must process all Medicare "crossover" claims (claims that include primary payment from Medicare) for QMBs, including Medicare-adjusted claims that are submitted by Medicaid-enrolled providers, even if a service or provider category is not currently recognized in the Medicaid State Plan. States must furnish all Medicare-enrolled providers, including out-of-state providers, with a means by which they can enroll in the Medicaid program for purposes of having such claims processed. This information is further discussed in the *CMCS – MMCO – CM Informational Bulletin* dated June 7, 2013 and issued by CMS, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-07-2013.pdf.

It is on this basis that we appeal the decision to deny the application submitted by Liberator Medical Supply, Inc. for participation in the Connecticut Medical Assistance Program. Enclosed you will find the CMCS – MMCO – CM – Bulletin from June 2013. We look forward to the opportunity to reestablish participation in the Connecticut Medical Assistance Program for claims processing of Medicare cost share amounts.

If there is any need for additional information or if you have any questions, please feel free to contact Robert O'Brien, Manager, IV and Contract Administration at (772) 341-7855 or Robert.O'Brien@liberatormedical.com.

Best Regards,

Claudio G. Araujo Filho
President
Liberator Medical Supply, Inc.