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

September 25, 2026 Sent Via Email

Trent Cooper (admin@hometownhhn.com)
Hometown Home Health and Nursing LLC
1905 Mountair Drive
Knoxville, TN 37924

Facility Type: Home Health Agencies
License Number: 734

Dear Trent Cooper:

It is my pleasure to inform you that your application for licensure of Hometown Home Health and Nursing LLC located at 301 Oak Ridge Turnpike, Oak Ridge, TN 37830 has been initially approved effective September 25, 2026. The license number shall be 734. 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 October 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 865-594-0730.

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,
Eddie J. Stewart
Eddie J. Stewart
Health Facilities Program Manager
Health Facilities Commission
Licensure Unit

cc: East Tennessee Regional Office

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HHA License # (if applicable): 734 County: Loudon

Add Counties _____ Initial X Renovation _____ Satellite/Off Campus Location_____

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

Facility Name: Hometown Home Health and Nursing LLC

Address: 301 Oak Ridge Turnpike Suite E City: Oak Ridge Zip Code: 37830

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): SN, HHA, Homemaker and Case Management EEOICPA

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

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

Total Licensed bed count:_____

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: *Jessika Lilly* Date: 9/24/2026

Fire Safety: _____ 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 ____ N/A
(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: 9/25/2026 Licensure is recommended: Yes ✓ No ____
(Completed by Central Office Licensure Staff)

De. Debra Verna/JL 9/24/2026
Regional Administrator/Facilities Construction Director or Designee Date

Eddie Stewart 9/25/2026
Licensure Program Unit Staff Date

State of Tennessee
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June 16, 2026 Sent Via Email

Trent Cooper (admin@hometownhhn.com)
Hometown Home Health and Nursing LLC
301 Oak Ridge Turnpike
Suite E
Oak Ridge, TN 37830

Dear Trent Cooper:

This is to acknowledge receipt of your application and fee to apply for licensure of Hometown Home Health and Nursing 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 details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey.

It is your responsibility to contact the Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to Tom A. Lane, Regional Administrator, 7175 Strawberry Plains Pike, Knoxville, Tennessee 37914. If you would like to email the request, you can email sara.e.walker@tn.gov.

Your application and fee will be held in a pending status until you are recommended by the 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.

In the event that 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) 741-7202 or you may email me at donald.black@tn.gov.

Sincerely,

Eddie J. Stewart
Eddie J. Stewart
Health Facilities Program Manag
Health Facilities Commission
Licensure Unit

ETRO emailed
ITSD 6/15/2026 (ejs)

RECEIVED JUN 01 2026

F# 734
A# 13370

HFC

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 Hometown Home Health and Nursing LLC

Location of the Facility:

Street 301 Oak Ridge Turnpike Suite E City Oak Ridge

County Anderson State TN Zip 37830

Phone Number (865) 800-3302 Fax Number (865) 800-3302

Twenty-four (24) Hour Emergency Phone Number (865) 800-3302

E-Mail Address Admin@hometownhhn.com

RECEIVED JUN 01 2026 BY

Administrator Information:

Administrator Trent Cooper

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 ✓

If yes, what charge(s)? _____

Location of Conviction _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name Hometown Home Health and Nursing LLC

Street 1905 Mountair Drive

City Knoxville State TN Zip 37924

Ownership of Building:

Name Commercial Realty Investment Group Phone Number (865) 693-3300

Street 8200 Kingston Pike

City Knoxville State TN Zip 37919

1. Check type: Hospital Based _____ Nursing Home Based _____ Free Standing ✓

2. Check type: Licensed only Agency ✓ Licensed/Medicaid Certified _____

3. Check type of services provided:

a. Skilled Nursing	✓	f. Home Health Aid Services	✓
b. Physical Therapy	____	g. Medical Supplies and Appliances	____
c. Occupational Therapy	____	h. Homemaker Services	✓
d. Speech Therapy	____	i. Other (please specify)	✓
e. Medical Social Services	____	Case management	

4. Do you have a Certificate of Need (CON)? Yes____ No ✓

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 ✓

If yes, what counties? _____

6. Is your agency a provider in the EEOICPA federal program? Yes ✓ No ____

If yes, what counties? All counties

7. 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 ____ Corporation ____ Limited Liability Company ✓

Church Related ____ Government/County ____ Other ____

b. Check one: For Profit ✓ Non-profit ____

c. Legal Entity checked in 1.a:

Name Hometown Home Health and Nursing LLC Phone Number (865) 216-1193

Address 1905 Mountain Drive, Knoxville, TN 37924

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

See attached sheet

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? _____

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.** No

Yes _____ No ✓ Expiration Date _____

3. Is this facility chain affiliated? Yes _____ No ✓

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

Name _____ Phone Number (____) _____

Address _____

5. a. If a corporation, is there a holding company? Yes _____ No ✓ N/A

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 ✓

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 ✓

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✓

ii) had a license suspended or revoked by any state licensure agency? Yes____No✓

iii) been subject to a final order or judgment in a state licensure action? Yes____No✓

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✓

c. Exclusion

i) excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes____No✓

(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✓

(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✓

f. Corporate Integrity Agreement

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes____ No✓

(Note: If yes, provide a copy of CIA)

g. Bankruptcy

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes____ No✓

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✓

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 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.

Applicant Signature	Administrator Title or Position	5-14-26 Date

STATE OF TENNESSEE

County of _____

The above named applicant (print name) TRENT COOPER, 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 14 day of MAY (Month) 2026 (Year)

Notary Public: Sophia Peterson

My commission expires: My Commission Expires Dec. 18, 2029

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

SOPHIA PETERSON
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY

Hometown Home Health and Nursing LLC

Members/Partners

Trent C. Cooper

Title: Administrator

119 Cooper Road

Heiskell, TN 37754

(865) 216-1193

Jackalyn S. Williams

Title: Office Manager

99 Mariner Point, Unit 1

Clinton, TN 37716

(423) 494-3454

Crystal A. McCammon

Title: Director of Nursing

1905 Mountair Drive

Knoxville, TN 37924

(423) 215-8830

Steven R. McCammon

Title: Chief Financial Officer

1905 Mountair Drive

Knoxville, TN 37924

(865) 201-1481

HOMETOWN HOME HEALTH & NURSING L.L.C.

Entity Type: Limited Liability Company (LLC)
Formed in: TENNESSEE
Term of Duration: Perpetual
Managed By: Member Managed
Series LLC: No
Number of Members: 6 or less

Status: Active
Control Number: 002104730
Initial Filing Date: 4/16/2026 11:30:26 PM
Fiscal Ending Month: December
AR Due Date: 04/01/2027
Obligated Member Entity: No

Registered Agent	Principal Office Address	Mailing Address
HOMETOWN HOME HEALTH & NURSING L.L.C.	1905 MOUNTAIR DR	1905 MOUNTAIR DR
1905 MOUNTAIR DR	KNOXVILLE, TN 37924	KNOXVILLE, TN 37924
KNOXVILLE, TN 37924		

AR Standing: Good | RA Standing: Good | Other Standing: Good | Revenue Standing: N/A

History (1)

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.

1. **REPORTING DATE:** 6-10-2026

2. **NAME AND ADDRESS OF PROVIDER**

Hometown Home Health and Nursing LLC
Name

1905 Mountair Drive
Address

Knoxville | TN | 37924
City | State | Zip

3. **CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION**

Trent Cooper | Administrator
Name | Title

admin@hometownhhn.com
Email Address

Hometown Home Health and Nursing LLC
Company Name

1905 Mountair Drive
Address

Knoxville | TN | 37924
City | State | Zip

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

5-31-2026

5. IF CURRENTLY LICENSED, PROVIDE LICENSE #:

LIST CURRENT LICENSED COUNTIES:

COUNTIES LICENSED UNDER EEOICPA:

COUNTIES LICENSED UNDER PEDIATRIC

COUNTIES LICENSED AS HOME INFUSION ONLY:

LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:

6. DESCRIPTION OF EXEMPTED ACTIVITY:

EEOICPA - Home Health Services - Skilled Nursing/HHA/Homemaker

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

PEDIATRIC:

EEOICPA:

All

7. **NAME AND ADDRESS OF PROVIDER**

Hometown Home Health and Nursing LLC
Name

1905 Mountain Drive
Address

Knoxville | TN | 37924
City | **State** | **Zip**

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

Please Check
(Be advised that some accreditation organizations require 10 or more patients at a minimum before starting accreditation proceedings.)

☒ 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.

Trent Cooper | 6-10-2026
Signature | **Date**

Trent Cooper
Printed Name

(865) 800-3302	(865) 800-3302
Phone Number	Fax Number