F-1566
ETRS/ATSD
Appl# 23932

RECEIVED
MAR 10 2026
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 Binson's Hospital Supplies, Inc.

Location of the Facility: Street 26834 Lawrence

County Macomb City Center Line

State MI Zip 48015

Phone Number (586) 755-2300 EXT 4372 CVerify 6/5/26 CNS Fax Number (586) 755-2322

Twenty-four (24) Hour Emergency Phone Numbe 586-755-2300 ext 4372 (Verified NS) 6/5/26

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (586) 755-2300

E-Mail Address robbynm@binsons.com

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

Administrator Information:

Administrator Robbyn Martin

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 XX

If yes, what charge(s)? _____

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

Mailing address if different from the Facility location address:

Name Same

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name ~~Company Owned~~ Binson's Hospital Supplies Inc Phone Number (**586**) **755-2300**

Street ~~26834 Lawrence~~

City ~~Center Line MI~~ MI Zip 48015
(Verified NS) 6/5/26

State

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*
Shipping of products to Tennessee residents.

out of State Michigan - verified CNS 6/5/26

2. Number of branch offices: ~~1 serving Tennessee residents.~~ 0 CNS

Address of each branch office: *(If additional space is needed, please use a separate page)*
No branch offices

3. **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___XX_ Corporation_____Limited Liability Company

_____Church Related _____Government/County _____Other

b. Check one: For Profit _XX___ Non-profit

c. Legal Entity checked in 1.a: _____ Phone Number (586) 755-2300
Name Binson's Hospital Supplies, Inc.
Street 26834 Lawrence State MI Zip 48015
City Center Line

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:
Verified CNS 6/5/26
James E. Binson 26834 Lawrence Center Line, MI 48015
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?

2. a. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.**
Yes XX No_____ Expiration Date 5-5-2027

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

Name NA Cverified NS 6/5/24 Phone Number (____) _____

Address _____

4. a. If a corporation, is there a holding company? Yes _____ No XX

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

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

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

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

_____

_____

6. a. Do you have a contract with a management firm to operate this facility? Yes_____ No XX

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:

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 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.

X 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	Title or Position	Date
Robbyn Mathis	Director	3-2-2026

STATE OF ~~TENNESSEE~~ MICHIGAN

County of MACOMB

The above named applicant (print name) Robbyn Martin, 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 2ND day of March (Month) 2026 (Year)

Notary Public: [signature]

My commission expires: _____

ELIZABETH ANDERSON
Notary Public - State of Michigan
County of Macomb
My Commission Expires Jun 23, 2027
Acting in the County of _____

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

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

July 28, 2026 Sent Via Email

Robbyn Martin
Binsons Hospital Supplies, Inc
26834 Lawerence
Center Line, Michgan 48015

Facility Type: Home Medical Equipment

Dear Robbyn Martin:

It is my pleasure to inform you that your application for licensure of Binson's Hospital Supplies, Inc located at 26834 Lawerence, Center Line, MI 48015 has been initially approved for providing DME/HME services in all counties in Tennessee effective June 5, 2026 . The license number shall be 1566. 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 August 26, 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

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

June 5, 2026 Sent Via Email

Robbyn Martin
Binsons Hospital Supplies, Inc
26834 Lawerence
Center Line, Michigan 48015

Facility Type: Home Medical Equipment

Dear Robbyn Martin:

It is my pleasure to inform you that your application for licensure of Binson's Hospital Supplies, Inc located at 26834 Lawerence, Center Line, Michigan 48015 has been initially approved for providing DME/HME services in all Counties in Tennessee effective June 5, 2026 . The license number shall be 1566. 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 22, 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.

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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): 1566 County: Macomb

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Binson's Hospital Supplies 26834 Lawrence Centerline MI 48015

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: 05/26/26

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: June 5, 2026 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

Tom Lane/ LB 5/29/2026
Regional Administrator/Facilities Construction Director or Designee Date

NRey SB 6/5/26
Licensure Program Unit Staff Date

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

Binson's Hospital Supplies, Inc.
d/b/a Binson's Home Health Care Centers
CENTER LINE, MICHIGAN

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

DMEPOS

Fitter Services, Home/Durable Medical Equipment Services,
Rehabilitation Technology Supplier Services

Accreditation #31659

FROM *May 6, 2024,* THROUGH *May 5, 2027*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIR OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC