F-1577
ETRO 1FTSD
APP.#24025
Recieved may 6, 2026

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 Diabetic Equipment and Supplies, LLC dba Diabetic Equipment and supplies CNS 7/27/26 Verified

Location of the Facility:

Street 1206 W Maumee St., Suite H City Angola

County Steuben State IN Zip 46703

Phone Number (515) 478-3600 Fax Number (515)478-3601

Twenty-four (24) Hour Emergency Phone Number (515) 478-3600 CNS)

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (515) 478-3600 CNS)

E-Mail Address info@diabeticequip.com

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

Administrator Information:

Administrator Marcus Miller - President/COO

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 ✓

If yes, what charge(s)? _____

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

Mailing address if different from the Facility location address:

Name Diabetic Equipment and Supplies

Street 6445 Corporate Drive

City Johnston State IA Zip 50131

Ownership of Building ~~Angola, IN~~

Name MMI of Angola LLC Phone Number (260) 246-3864

Street 2721 Chichester Lane

City Fort Wayne State IN Zip 46815

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*
Nationwide - Drop Ship Physician Prescribed Medical Supplies direct to patient homes.
All Counties in Tennessee Out of State Indiana (CNS)

2. Number of branch offices: 00 (CNS)

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

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 _____Corporation ✓ Limited Liability Company

_____Church Related _____Government/County _____Other

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

c. Legal Entity checked in 1.a:

Name Diabetic Equipment and Supplies, LLC Phone Number (515) 478-3600

Street 6445 Corporate Drive

City Johnston State IA Zip 50131

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

Please refer to the attached

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 ✓

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 ✓ No _____ Expiration Date The ComplianceTeam 04/10/2028

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

Name_____ Phone Number (____)_____

Address _____

4. a. If a corporation, is there a holding company? Yes____ No ✓

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 ✓

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 ✓

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 ✓

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)

SARAH HENRY
Commission Number 8-10928
My Commission Expires

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 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	President/COO Title or Position	05/04/2026 Date

STATE OF TENNESSEE

County of Polk

The above named applicant (print name) Marcus Miller, 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 4th day of May (Month) 2026 (Year)

SARAH HENRY
Notarial Seal - Iowa
Commission Number 840928
My Commission Expires
7-19-28

Notary Public: Sarah Henry

My commission expires: 7-19-28

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 27, 2026

Sent Via Email

Marcus Miller - President/COO
Diabetic Equipment and Supplies, LLC dba Diabetic Equipment & Supplies
1206 W.Maumee Street Suite H
Angola, Indiana 46703

Facility Type: Home Medical Equipment

Dear Marcus Miller:

It is my pleasure to inform you that your application for licensure of Diabetic Equipment and Supplies, LLC dba Diabetic Equipment & Supplies located at 1206 W Maumee St, Suite H, Angola, Indiana 46703 has been initially approved for Providing DME/HME services in all counties of Tennessee effective July 27, 2026 . The license number shall be 1577. 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

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1577 County: Steuben

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Diabetic Equipment & Supplies, LLC dba Diabetic Equipment & Supplies

1206 W. Maumee Street Suite H Angola, IN 46703

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: 07/20/26

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: July 27, 2026 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

Dr. Debra Verna/KT 7/24/2026

Regional Administrator/Facilities Construction Director or Designee Date

Licensure Program Unit Staff 7/27/26 Date

Certificate of Accreditation

Exemplary Provider® Award

Granted To

Diabetic Equipment and Supplies LLC

Diabetic Equipment and Supplies

1206 W Maumee St Ste H Angola, IN 46703

for demonstrating

Outstanding Healthcare Delivery Practices

and

Compliance to

Safety • Honesty • Caring®

Accreditation Quality Standards

DMEPOS

EXPIRATION DATE: APRIL 10, 2028

Founder & CEO, The Compliance Team, Inc.

037682

April 10, 2025

Date

DMEPOS

PHARMACY

RURAL HEALTH

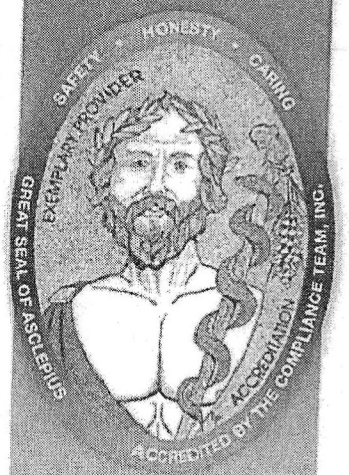
PATIENT-CENTERED MEDICAL HOME

CLINIC

PHYSICIAN

INFUSION

OCULARIST



The Promise of HEALTHCARE EXCELLENCE

Diabetic Equipment and Supplies, LLC
Ownership Summary
TN HME License Application: Ownership of Business 1. D

Name of Individual or Entity	Title	Ownership %	Address
Todd Dean Carlson Irrevocable Trust		**85%**	**4581 Brynwood Dr** **Naples, FL 34119**
Randy Carlson	Trustee		
Todd Carlson	Board Chairman		
Marcus Miller	**Board Member - President/COO**	**5%**	**112 42nd St** **Des Moines, IA 50312**
MBKJ, LLC	**Board Member**	**5%**	**208 NE 24th CT** **Grimes, IA 50111**
Schutjer Family Farms, LLC	**Board Member**	**5%**	**4402 NE Rio CT** **Ankeny, IA 50021**

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DMEPOS

EXPIRATION DATE: APRIL 10, 2028

Founder & CEO, The Compliance Team, Inc.

037682

April 10, 2025

Date

DMEPOS

PHARMACY

RURAL HEALTH

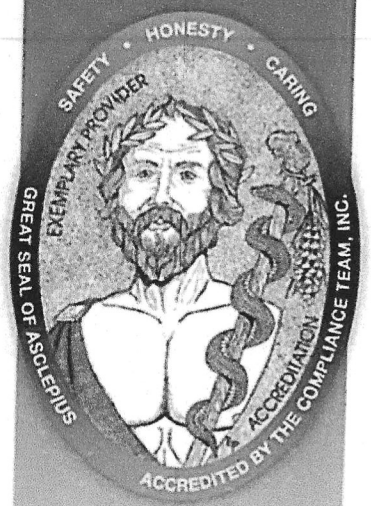
PATIENT-CENTERED MEDICAL HOME

CLINIC

PHYSICIAN

INFUSION

OCULARIST



The Promise of HEALTHCARE EXCELLENCE

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

May 6, 2026

Sent Via Email

Marcus Miller, President/COO
Diabetic Equipment and Supplies, LLC
1206 W Maumee St, Suite H
Angola, Indiana 46703

Dear Marcus Miller :

This is to acknowledge receipt of your application and fee to apply for licensure of Diabetic Equipment and Supplies, 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 Tom Lane ,East Tennessee Regional Administrator,7175 Strawberry Plains Pike, Suite103 Knoxville, Tennessee 37914 . If you would like to fax the request to the fax number is 865-594-0739.

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) 741-7539 or you may email me at Niraj.Soni@tn.gov.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov