WTRO/FTSD

Application Summary

F-1579, App# 24031

Application Detail

License Type:	**Home Medical Equipment: Licensed**
Application:	**Home Medical Equipment: Initial Application**
Application Date:	**05/12/2026 (mm/dd/yyyy)**

Organization Detail

Organization Name:	**KabaFusion TN, LLC**
Organization Type:	**Limited Liability Company**

Addresses

Main Address

Address:	**2970 Sidco Drive** **DAVIDSON** **Nashville, TN** **37204** **US**
Phone Number:	**877-397-8341**
Extension:	
E-mail Address:	**kabafusionlicensing@kabafusion.com**

Administrative

Name:	**KabaFusion**
Address:	**17777 Center Court Drive N** **Suite 550** **LOS ANGELES** **Cerritos, CA** **90703** **US**
Phone Number:	**800-435-3020**
Extension:	

E-mail Address: **kabafusionlicensing@kabafusion.com**

Emergency Contact

Name: **KabaFusion TN, LLC**

Address: **2970 Sidco Drive**

DAVIDSON

Nashville, TN

37204

US

Phone Number: **877-397-8341**

Extension:

E-mail Address: **kabafusionlicensing@kabafusion.com**

Ownership of Building

Name: **Meadows Family General Partnership**

Address: **395 Franklin Rd**

WILLIAMSON

Franklin, TN

37069

US

Phone Number: **615-347-9394**

Extension:

E-mail Address: **greg@crown.com**

Legal Entity

Name: **KabaFusion TN, LLC**

Address: **2970 Sidco Drive**

DAVIDSON

Nashville, TN

37204

US

Phone Number: 877-397-8341

Extension:

E-mail Address: kabafusionlicensing@kabafusion.com

License Attributes Selected

Qualification/Certification

~~Anderson~~

~~Bedford~~

~~Benton~~

~~Bledsoe~~

~~Blount~~

~~Bradley~~

~~Campbell~~

~~Cannon~~

~~Carroll~~

~~Carter~~

~~Cheatham~~

~~Chester~~

~~Claiborne~~

~~Clay~~

~~Cocke~~

~~Coffee~~

~~Crockett~~

~~Cumberland~~

~~Davidson~~

~~DeKalb~~

~~Decatur~~

~~Dickson~~

~~Dyer~~

Verified
7/13/26
CNS

~~Fayette~~

~~Fentress~~

~~Franklin~~

~~Gibson~~

~~Giles~~

~~Grainger~~

~~Greene~~

~~Grundy~~

~~Hamblen~~

~~Hamilton~~

~~Hancock~~

~~Hardeman~~

Hardin

Hawkins

Haywood

Henderson

Henry

Hickman

Houston

Humphreys

Jackson

Jefferson

Johnson

Knox

Lake

Lauderdale

Lawrence

Lewis

(Verified)
NS
7/13/26

Lincoln

Loudon

Macon

Madison

Marion

Marshall

Maury

McMinn

McNairy

Meigs

Monroe

Montgomery

Moore

Morgan

Obion

Overton

Perry

Pickett

Polk

Putnam

Rhea

Roane

Robertson

Rutherford

Scott

Sequatchie

Sevier

Shelby

Verified
NS
7/13/26

	Smith
	Stewart
	Sullivan
	Sumner
	Tipton
	Trousdale
	Unicoi CV verified NS 7/13/26
	Union
	Van Buren
	Warren
	Washington
	Wayne
	Weakley
	White
	Williamson
	Wilson
Additional License Information	**For Profit** All counties of Tennessee

Basic License Data

If your facility has branch offices provide the number. If none, enter 00	**00**
Provide Administrator's Name:	**Angela Sheehy**
Provide the Ownership's Name:	**KabaFusion** TN, LLC
Is your facility accredited by a federally approved accrediting body?	**Yes**
If answered yes accredited, must provide expiration date of accreditation.	**09/29/2028 (mm/dd/yyyy)**
What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?	**Free Standing**
Provide a Yes or No, if your facility is Chain Affiliated:	**No**

Provide a Yes or No, if your facility is Chain Affiliated:	
Provide a Yes or No, if your facility has a Holding Company:	**No**
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	**Yes**
Provide a Yes or No, if your facility has a parent company:	**No**
Do you have a contract with a management firm to operate this facility?	**No**
Have any owners ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state?	~~Yes~~ No, CNS 7/13/26 (Verified)
Does your facility have a physical location in Tennessee?:	**Yes**

Administrator Conviction Information

Administrator convicted of crime?:	**No**

Individual Owners, Partners, Director or Head of Government Entity 1

The name of the individual owner, partner, director of the corporation or head of the government:	**Sohail Masood**
Street:	**17777 Center Court Drive N, Suite 550**
City:	**Cerritos**
State:	**California**
Zip:	**90703**

Individual Owners, Partners, Director or Head of Government Entity 2

The name of the individual owner, partner, director of the corporation or head of the government:	**Sohail Merchant**
Street:	**17777 Center Court Drive N, Suite 550**
City:	**Cerritos**
State:	**California**
Zip:	**90703**

Individual Owners, Partners, Director or Head of Government Entity 3

The name of the individual owner, partner, director of the corporation or head of the government:	**Aslam Masood**
Street:	**17777 Center Court Drive N, Suite 550**
City:	**Cerritos**
State:	**California**
Zip:	**90703**

Individual Owners, Partners, Director or Head of Government Entity 4

The name of the individual owner, partner, director of the corporation or head of the government:	**Tina Benkendorfer**
Street:	**17777 Center Court Drive N, Suite 550**
City:	**Cerritos**
State:	**California**
Zip:	**90703**

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?:	~~Yes~~ NO, CNS) 7/13/26 *verified.
Have any of owners of the disclosing entity had a suspension of admissions?:	**No**
Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state?:	**No**

File Attachments

Proof of financial ability.pdf

Fees

Initial License Fee	**$1404.00**
Total Amount Due:	**$1404.00**

Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the

Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Home Medical Equipment facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Home Medical Equipment facility. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

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 13, 2026

Sent Via Email

Angela Sheehy
KabaFusion TN, LLC
2970 Sidco Drive
Nashville, Tennessee 37204

Facility Type: Home Medical Equipment

Dear Angela Sheehy:

It is my pleasure to inform you that your application for licensure of KabaFusion TN, LLC located at 2970 Sidco Drive, Nashville, TN 37204 has been initially approved for Home Medical Equipment provider infusion services to all counties of Tennessee effective July 13, 2026 . The license number shall be 1579. 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 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): #1579 County: Davidson

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Kabafusion TN. LLC _____

Address: 2970 Sidco Drive City: Nashville Zip Code: 37204

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): Home Medical Equipment provider Infusion services to 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: 6/16/26

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A____

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 ____ N/A
(NOTE: With exception of Initial Licensure Approvals)

Effective date: July 13, 2026 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

ACC Supervision 6/18/2026
Regional Administrator/Facilities Construction Director or Designee Date

7/13/26
Licensure Program Unit Staff Date

Administrator is Robert Seftel: Support@conduithealth.com
Please send copy to Alex Zajac: Alex@Conduithealth.com

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

KabaFusion TN, LLC

NASHVILLE, TENNESSEE

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

Home/Durable Medical Equipment Services

Accreditation #89466

FROM *September 30, 2025,* THROUGH *September 29, 2028*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIR OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC

Niraj Soni

From: Smita Njeru, RPh <SNjeru@kabafusion.com>
Sent: Monday, July 13, 2026 11:54 AM
To: Niraj Soni
Cc: Ellen Paras, BSc.
Subject: [EXTERNAL] KabaFusion TN, LLC License # 1579
Attachments: Accreditation Certificate ACHC DME.pdf; Response to Owner discipline question.pdf

Good afternoon, Mr. Soni,

Thank you for taking the time to speak with me today. Pursuant to your request, please see attached the following:

1. Accreditation Certificate ACHC DME, expiring 9/29/2028.
2. In response to the application question, **"Have any owners ever been denied a license, had a license suspended or revoked, had a suspension of admission, or paid any civil monetary penalties for a health care facility in Tennessee or any other state?"**, we answered **"Yes"** out of an abundance of caution and to ensure full disclosure.

   However, following our recent telephone discussion, we understand that the appropriate response should have been **"No."** The matter in question involved a temporary denial of a request to add several additional service counties to one of our licensed locations in New York. This was not a denial, suspension, or revocation of the facility's license itself. The initial decision was subsequently reversed, and the requested counties were approved and added to the location's service area. At no time was the facility's license denied, suspended, or revoked, nor were any civil monetary penalties assessed or paid. Accordingly, we respectfully clarify that the correct response to the application question is **"No."**

   I've attached the "Response to Owner discipline question" document for your records.

I appreciate all your help and guidance through this process.

Smita Njeru RPh, MBA, CHC
SVP Regulatory Compliance | **KabaFusion**
a: 17777 Center Court Drive North, Suite 550 | Cerritos, CA | 90703
o: (213) 286-3734| m: 562.965.9757 | f: 562.472.2633
e: snjeru@KabaFusion.com | w: KabaFusion.com

KabaFusion
Patient-Focused Infusion Therapy

Licensure Denial for Additional Location of Lincare of New York, Inc. (Newburgh)

Lincare of New York, Inc. (a KabaFusion company) submitted an application for an additional location in Newburgh to be added to its master license to expand its operations within the state of New York. In a letter dated 1/09/2023, the New York Department of Health initially denied the additional location in Newburgh due to a review that was being conducted regarding another separate location of Lincare of New York, Inc.

After further follow up between Lincare of New York, Inc. and the New York Department of Health, a letter dated 3/23/2023 confirmed that the Newburgh location was successfully added to the master license with a retroactive effective date of 8/29/2022.

A copy of the referenced letters and the license that was issued are enclosed.

CORPORATE (WEST COAST)
17777 Center Court Dr., Ste. 550, Cerritos, CA 90703
P: 800-435-3020 F: 562-860-6017

CORPORATE (EAST COAST)
80 Hayden Ave., Suite 300, Lexington, MA 02421
P: 844-777-4844 F: 781-862-2002

www.KabaFusion.com