



F-1589
App # 24079
ETK 01/ETSD

Received
5/28/26

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 Wilmington Medical Supply, Inc

Location of the Facility:

Street 5815 Oleander Dr Unit 310

City Wilmington

County New Hanover

State NC

Zip 28403

Phone Number (910) 392-5553

Fax Number (888) 718-0633

Twenty-four (24) Hour Emergency Phone Number (877) 688-2729

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (877) 688-2729

E-Mail Address 180-Accreditation@180medical.com

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

Administrator Information:

Administrator Jeffery Hendrix

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 _____

(City)

(County)

(State)

Date _____

Mailing address if different from the Facility location address:

Name Wilmington Medical Supply, Inc - Attn: Sara Munoz

Street 8516 NW Expressway

City Oklahoma City

State OK

Zip 73162

Ownership of Building:

Name Mashke, LLC

Phone Number (910) 232-8913

Street 5815 Oleander Drive

City Wilmington

State

NC

Zip 28403

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

2. Number of branch offices: 0

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 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 Wilmington Medical Supply, Inc Phone Number 877-688-2729
Street 5815 Oleander Dr. Unit 310
City Wilmington State North Carolina Zip 28403

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

Mark Jassey 524 NW 16th St Oklahoma City, OK 73103
Name Street City, State, Zip

Jeffery Hendrix 9008 NW 148th Pl Yukon, OK 73099
Name Street City, State, Zip

John Holtz 5714 Reef Landing Way Wilmington, NC 28409
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 X No ____ Expiration Date 10/12/2028

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 X

- 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 X No _____ CNS 7/27/26

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

Wilmington Medical Supply 100 Main St. Suite 102
Whitonsville, MA. 01588

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:

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 have been implemented (as applicable).

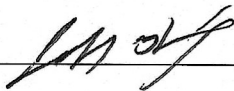
VERIFICATION BY NOTARY PUBLIC:

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



CFO

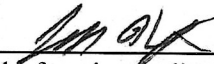
Title or Position

5.7.20

Date

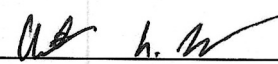
STATE OF TENNESSEE

County of Oklahoma

The above named applicant (print name) Jeffery Hendrix , 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 7th day of May 2024
(Month) (Year)



Notary Public: 

My commission expires: 9/30/2028

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

Jeffrey Hendrix
Wilmington Medical Supply, Inc
5815 Oleander Drive Unit 310
Wilmington, North Carolina 28403

Facility Type: Home Medical Equipment

Dear Jeffrey Hendrix:

It is my pleasure to inform you that your application for licensure of Wilmington Medical Supply, Inc located at 5815 Oleander Dr Unit 310, Wilmington, North Carolina 28403 has been initially approved for providing DME/HME services in all counties in Tennessee effective July 27, 2026 . The license number shall be 1589. 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



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1589 County: New Hanover

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Wilmington Medical Supply Inc 5815 Oleander Drive Unit 310 Wilmington, N.C. 28403

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: 07/22/26

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
(Completed by Central Office Licensure Staff)

Licensure is recommended: Yes X No _____

Dr. Debra Verna/ KT

7/24/2026

Regional Administrator/Facilities Construction Director or Designee

Date

Nancy San
Licensure Program Unit Staff

Date

CERTIFICATE of ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

Wilmington Medical Supply, Inc WILMINGTON, NORTH CAROLINA

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:

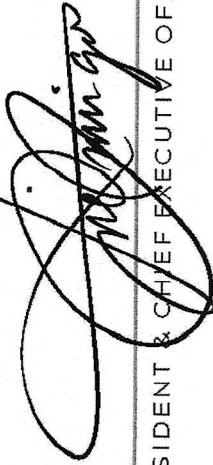
DMEPOS

Medical Supply Provider Services

Accreditation #76930

FROM October 13, 2025, THROUGH October 12, 2028





PRESIDENT & CHIEF EXECUTIVE OFFICER



CHAIR OF THE BOARD OF COMMISSIONERS