State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

June 4, 2024 **Sent Via Email**

Natascha Amster
AdaptHealth Patient Care Solutions LLC
220 W. Germantown Pike, Suite 250
Plymouth Meeting, Pennsylvania 19462-1437

Facility Type: Home Medical Equipment

Dear Administrator:

It is my pleasure to inform you that your application for licensure of AdaptHealth Patient Care Solutions LLC located at 600 Lindbergh Drive, Moon Township, Pennsylvania 15108-2777 for has been initially approved for Home Medical Equipment services to all Tennessee Counties; effective June 3, 2024. The license number shall be 1424. For this initial approval to become final and permanent, your application must be ratified by the Board pursuant to T.C.A. §68-11-206. The Board will consider your application at its next meeting, scheduled for July 31, 2024. **You are hereby authorized to commence operation pending the final decision of the Board**. No further action is necessary on your part currently.

For certification purposes, please be advised it is your responsibility to contact your Health Care Facility's regional office for participation in Medicare/Medicaid. The East Regional Office phone number is 865-594-9396.

If the Board **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 Board's final decision.

If the Board **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,

Mary Louise Clark

Mary Louise Clark, ASA II

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): _____ County: _____

Initial _____ Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Adapt Health Patient Care Solutions LLC

Address: 600 Lindbergh Dr City: Moon Township PA Zip Code: 37918

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): Providing HME services to all counties in 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: Roberta L. Anderson Date: 6-3-24

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A____ Health Survey Required: Yes____ No____

Facility's Letter of Notification received in Licensure: Yes ____ No ____
(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: 6/3/2024 Licensure is recommended: Yes x No ____
(Completed by Central Office Licensure Staff)

x Debra Verna 6/3/24
Regional Administrator/Facilities Construction Director or Designee Date

Mary Louise Clark 6/4/2024
Licensure Program Unit Staff Date

State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-7221

January 10, 2024 **Sent Via Email**

Natascha Amster
AdaptHealth Patient Care Solutions LLC
600 Lindbergh Drive
Moon Township, Pennsylvania 15108-2777

Dear Natascha Amster:

This is to acknowledge receipt of your application and fee to apply for licensure of AdaptHealth Patient Care Solutions 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 Services and Developmental Agency* at (615) 741-2364.

Please remember that if you are applying for licensure of a facility that requires an architectural plans 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 East Tennessee, Regional Administrator, 7175 Strawberry Plains Pike, Suite 103, Knoxville, Tennessee 37914. If you would like to fax the request to Debra Verna) the fax number is 865-594-5739.

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 Care Facilities for ratification and final approval at the next regularly scheduled board meeting. Your facility CAN operate once you receive the "Initial Approval."

This application will only be good for one (1) years 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 Mary.2.Clark@tn.gov.

Sincerely,

Mary Louise Clark

Mary Louise Clark, ASA II

ITSD/East file# 1424 App# 22915

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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/hsda/health-care-facilities/hcf-main/licensure.html. Please check this website periodically for updates.

Name of the Facility/Agency AdaptHealth Patient Care Solutions LLC

Location of the Facility:

Street 600 Lindbergh Drive City Moon Township

County Allegheny State PA Zip 15108-2777

Phone Number ( ) 412-226-9605 Fax Number ( ) 800-749-0711

Twenty-four (24) Hour Emergency Phone Number ( ) 412-226-9605

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week ( ) 412-226-9605

E-Mail Address licensing@adapthealth.com

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

Administrator Information:

Administrator Natascha Amster

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 _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name AdaptHealth Patient Care Solutions LLC

Street 220 W. Germantown Pike, Suite 250

City Plymouth Meeting State PA Zip 19462-1437

Ownership of Building:

Name Airside Business Park LP Phone Number ( ) 412.925.3954 Todd McCaskey

Street 1 Bigelow Square

City Pittsburgh State PA Zip 15219

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

1. Are you a provider providing manufactured or distributing company-branded Insulin Infusion Pumps and related supplies? **Yes**_____ **No** X ***(If so, the following are requirements, which must be met)***.

   a. ***Do you have an employee presence within the state of Tennessee?*** ***Yes***____***No***____
   (Please describe the nature of the employee's physical presence in the state)_____
   _____

   b. ***Provide Joint Commission Accreditation (JCAHO). (Please provide JCAHO letter and complete report in accordance with T.C.A. TCA 68-11-226(e))***

2. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*
   All Counties

3. Number of branch offices: 0

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

4. 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__X__Limited Liability Company

   _____Church Related _____Government/County _____Other

   b. Check One: __X__For Profit_____Non-profit

   c. Legal Entity checked in 1.a:

   Name AdaptHealth Patient Care Solutions LLC Phone ( ) 610-630-6357

   Address 220 W. Germantown Pike, Suite 250, Plymouth Meeting, PA 19462-1437

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

Name	Street	City, State, Zip
Yehoshua Parnes, President	220 W. Germantown Pike, Suite 250, Plymouth Meeting, PA 19462-1437	
Jason Clemens, CFO	220 W. Germantown Pike, Suite 250, Plymouth Meeting, PA 19462-1437	
Wendy Russalesi, Chief Compliance Officer	220 W. Germantown Pike, Suite 250, Plymouth Meeting, PA 19462-1437	

   (If additional space is needed, please use a separate sheet)

2. a. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? Yes __X__No_____ Expiration Date 03.13.2024

b. Is your facility/organization deemed by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? Yes X No _____ Expiration Date 03.13.2024

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

Name NRE Holding LLC Phone Number ( ) 610-630-6357

Address 220 W. Germantown Pike, Suite 250, Plymouth Meeting, PA 19462-1437

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

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

_____

_____

5. 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

6. a. Have any owners of the disclosing entity 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 X

b. If yes, where?_____ When? _____

c. For what reason? _____

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.

Natasha Amster _____ Licensing & Governmental Credentialing Specialist 01/09/2024

Applicant Signature Title or Position Date

_____

HF-3639 (Rev 6/2023) RDA-1165

STATE OF TENNESSEE

County of Chester

The above named applicant (print name) Natascha Amster, 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 9th day of January 2024
(Year)

Notary Public: Joseph J. Paiva

Commonwealth of Pennsylvania - Notary Seal
Joseph Paiva, Notary Public
Montgomery County
My Commission Expires Jul 10, 2027
Commission Number 1353947

My commission expires: July 10, 2027

HF-3639 (Rev 6/2023) RDA-1165

TN Department of Health

Online Payment Receipt

Receipt Issued By:
Board for Licensing Health Care Facilities

Receipt Issued To:
Diane Siegel
16 Maplewood Ct
Greenbelt, MD 20770

Date: 01/02/2024
Transaction Identifier: 3865071827
Trace Number: 1848888

License Type	Licensee	Transaction	Application #	Account #	Amount
Home Medical Equipment	AdaptHealth Patient Care Solutions LLC	Home Medical Equipment: Initial Application	548-22915	**********0216	$1404.00

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

AdaptHealth Patient Care Solutions LLC

MOON TOWNSHIP, PENNSYLVANIA

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 #82612

FROM *November 1, 2021* THROUGH *March 13, 2024*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC