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

June 11, 2024

Sent Via Email

Michael Heaney
Electronic Waveform Lab, Inc.
5702 Bolsa Avenue
Huntingtn Beach, California 92649

Facility Type: Home Medical Equipment

Dear Administrator:

It is my pleasure to inform you that your application for licensure of Electronic Waveform Lab, Inc. located at 5702 Bolsa Avenue, Huntingtn Beach, California 92649 has been initially approved to provide Home Medical Equipment services to all counties in Tennessee; effective June 10, 2024. The license number shall be 1394. 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 . **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 X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Electronic Waveform Lab, Inc.

Address: 5702 Bolsa Avenue City: Huntington Beach CA Zip Code: 92649

Application and fee on file in Central Office (CO)?: Yes ____ No ____ CON #: _____

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): To provide 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: Loretta L. Anderson Date: 6-10-24

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: 6/10/24 Licensure is recommended: Yes __X__ No ____

(Completed by Central Office Licensure Staff)

X Debra Ver 6/10/24

Regional Administrator/Facilities Construction Director or Designee Date

Mary Louise Clark 6/11/24

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

September 11, 2023 **Sent Via Email**

Michael Heaney
Electronic Waveform Lab, Inc.
5702 Bolsa Avenue
Huntington Beach, California 92649

Dear Michael Heaney:

This is to acknowledge receipt of your application and fee to apply for licensure of Electronic Waveform Lab, Inc. 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 2

East/ITSD file# 1394 app# 22790

HFC

RECEIVED SEP 11 2023

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 Electronic Waveform Lab, Inc.

Location of the Facility:

Street 5702 Bolsa Avenue City Huntington Beach

County Orange State California Zip 92649

Phone Number (714)843-0463 Fax Number (714) 948-8203

Twenty-four (24) Hour Emergency Phone Number (714)642-2720

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (714) 642-2720

E-Mail Address Mheaney@h-wave.com

Does your facility have a physical location in the state of Tennessee? Yes_____ No__X____

Administrator Information:

Administrator Michael Heaney

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 N/A

Street

City State Zip

Ownership of Building:

Name HB Capital (Heaney Family) Phone Number (714) 642-2720

Street 5702 Bolsa Ave.

City Huntington Beach State CA Zip 92649

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 X No____***
   (Please describe the nature of the employee's physical presence in the state)
   1 Sales Representative that meets and educates doctors on the H-Wave electrical stimulation device.

   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.*
   Our Electrical Stimulation Devices could be mailed to every county in Tennessee.

3. Number of branch offices: 0

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

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__X____Corporation_____Limited Liability Company

   _____Church Related _____Government/County _____Other

   b. Check One: __X___For Profit_____Non-profit

   c. Legal Entity checked in 1.a:

   Name Electronic Waveform Lab, Inc._____Phone (714) 843-0463

   Address 5702 Bolsa Ave Huntington Beach, CA 92649

   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
William Heaney	16292 Walrus lane.	Huntington Beach, CA 92649
Name	Street	City, State, Zip
Ryan Heaney	9812 Oceancrest Drive	Huntingtin Beach, CA 92649
Name	Street	City, State, Zip
William Heaney III	16281 Sundancer Lane	Huntingtin Beach, CA 92649
Name	Street	City, State, Zip

   (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 _____No__X____ Expiration Date _____

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

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

Name _____ Phone Number (____) _____

Address _____

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.

Applicant Signature	QA Title or Position	9/7/23 Date

STATE OF CALIFORNIA

County of Orange

The above named applicant (print name)_____, 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 7 day of Sept (Month) 2023 (Year)

Notary Public: [signature]

NATALIE KAY STEWART GAMBALE
Notary Public - California
Orange County
Commission # 2441824
My Comm. Expires Mar 20, 2027

My commission expires: _____

CALIFORNIA NOTARIAL CERTIFICATE
(JURAT)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Orange

Subscribed and sworn to (or affirmed) before me on this 7 day of Sept, 20 23 by Michael Heaney, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature _____ (Seal)

NATALIE KAY STEWART GAMBALE
Notary Public - California
Orange County
Commission # 2441824
My Comm. Expires Mar 20, 2027

Tennessee Department of Health
Cash Listing Report

Client:	5 - Board for Licensing Health Care Facilities			**Origin:**	Deposit	**Fiscal Year:**	2024
Batch #:	85	**Total $ Entered:**	$ 1,404.00	**Deposit #:**	08302023	**Deposit Date:**	2023-08-30
# Receipt:	1	**Receipts Entered:**	1	**Total:**	$ 1,404.00	**Status:**	Deposited

Receipt #	DLN	Received	Disp	Pmt	Bad Check?	Unassigned	Prof	Remitted By / Beneficiary	File #	License #	Assigned
235	36245873	$ 1,404.00	DEP	CHK		$ 1,404.00	548	ELECTRONIC WAVEFORM LAB, INC.	1394		
Total:		$ 1,404.00				$ 1,404.00					

**** DUPLICATE ****

STATE OF TENNESSEE
Health Services and Dev Agency
Office:Andrew Jackson, 8t
8/30/2023 12:24 PM

Cashier: MARYL1011002
Batch #: 1539988
Trans #: 3

Health Care Facilities
eipt #: 36245873
5 HCF $1,404.
ment Total: $1,404.

nsaction Total: $1,404.

Check 21 $1,404.00

Thank you your payment.
Have a nice day!