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

HFC

July 9, 2024

Sent Via Email

David Siegel
Nationwide Medical, Inc.
5230 Las Virgenes Road, Ste. 105
Calabasas, California 91302

Facility Type: Home Medical Equipment

Dear Administrator:

It is my pleasure to inform you that your application for licensure of Nationwide Medical, Inc. located at 5230 Las Virgenes Road, Suite 105, Calabasas, California 91302 has been initially approved for Home Medical Equipment serving all Tennessee counties; effective July 2, 2024. The license number shall be 1438. 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 29, 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 West Regional Office phone number is 731-984-9684.

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): 1438 County: Out of State

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Nationwide Medical Inc.

Address: 5230 Las Virgenes Rd., Ste 105 City: Calabasas, CA Zip Code: 91302

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): Home Medical Equipment provider serving 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: Celia Skelley RN PHNC1 Date: 06/27/2024

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: 7/2/2024 Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

Kathy Zeigler/DPM 07/02/2024
Regional Administrator/Facilities Construction Director or Designee Date

Mary Louise Clark 7/9/2024
Licensure Program Unit Staff Date

Please send copy of approval to B.Oliver@nationwidemedical.com

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

HFC

May 16, 2024

Sent Via Email

Nationwide Medical, Inc.
5230 Las Virgenes Road, Suite 105
Calabasas, California 91302

Dear Nationwide Medical, Inc.:

This is to acknowledge receipt of your application and fee to apply for licensure of Nationwide Medical, 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 West Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to West Tennessee, Regional Administrator, 295 Summar Drive, Floor 2, Jackson, Tennessee 38301. If you would like to fax the request to Kathy Zeigler) the fax number is 731-427-0407.

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) 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) 741-7202 or you may email me at Mary.2.Clark@tn.gov.

Sincerely,

Mary Louise Clark

Mary Louise Clark, ASA II

West / ITSD file# 1438
App#23062

RECEIVED MAY 15 2024

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 Nationwide Medical, Inc.

Location of the Facility:

Street 5230 Las Virgenes Rd. STE 105 City Calabasas

County Los Angeles State California Zip 91302

Phone Number (818) 338-3500 Fax Number (818) 338-3501

Twenty-four (24) Hour Emergency Phone Number (818) 338-3500

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (818) 338-3500

E-Mail Address patientservices@nationwidemedical.com

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

Administrator Information:

Administrator David Siegel

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 (same)

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name Realty Bancorp Equities Phone Number (818) 251-9911

Street 21800 Oxnard St. STE 500

City Woodland Hills State CA Zip 91367

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*** X
   (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__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 Nationwide Medical, Inc. Phone Number (818) 338-3500

   Street 5230 Las Virgenes Rd. STE 105

   City Calabasas State CA Zip 91302

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

   (See 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 _____ N/A

f. If no to e., who has said authority? N/A

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 HQRA No _____ Expiration Date 2/7/2026

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

Name N/A 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 N/A 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 X

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

N/A

_____

6. a. Do you have a contract with a management firm to operate this facility? Yes _____ No X

If yes, specify dates: From N/A To _____

b. If yes, please specify name of firm: N/A

Phone Number (___) _____

_____

Street City, State, Zip

7. 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	Title or Position	Date
[signature]	CEO	3-11-24

STATE OF TENNESSEE

County of _____

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_____day of _____
(Month) (Year)

Notary Public: _____

My commission expires: _____

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

CALIFORNIA JURAT **GOVERNMENT CODE § 8202**

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 Los Angeles

Subscribed and sworn to (or affirmed) before me on this 11th day of March, 2024, by

(1) David Siegel

(and (2) _____),

Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

HOLLY ANGELES
Notary Public - California
Los Angeles County
Commission # 2446598
My Comm. Expires Jun 5, 2027

Place Notary Seal and/or Stamp Above

Signature _____
Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Home Medical Equipment Application for Initial Licensure

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

*** * * * D U P L I C A T E * * * ***

STATE OF TENNESSEE
Health Services and Dev Agency
Office:Andrew Jackson, 8t
3/20/2024 2:04 PM

Cashier: JENNB0621001
Batch #: 1587826
Trans #: 1

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Health Care Facilities

Receipt #: 37386099

HA15	HCF	$1,404.00
Payment Total:		**$1,404.00**

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Transaction Total: **$1,404.00**

Check 21 $1,404.00

Thank you for your payment.
Have a nice day!

*** * * * D U P L I C A T E * * * ***

NATIONWIDE
MEDICAL, INC.

Date: March 13, 2024

Tennessee Health Facilities Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Initial Licensure Application for Nationwide Medical, Inc.
TIN: 611423158

To Whom It May Concern,

We are requesting to be licensed as a Home Medical Equipment Provider to service patients in Tennessee. Nationwide Medical, Inc. is a DME company that has been in business for over 21 years. We service patients all over the country and are excited to potentially service patients in Tennessee.

Let me know if you have any questions and please do not hesitate to contact me via phone or email.

Sincerely,

Brian Oliver, CHC
Chief Compliance Officer
Nationwide Medical, Inc.
Phone: 818-338-3522
Email: boliver@nationwidemedical.com