



**State of Tennessee  
Health Facilities Commission**

502 Deaderick Street, Andrew Jackson Building, 9<sup>th</sup> Floor, Nashville, TN 37243  
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

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**INITIAL APPLICATION FOR LICENSE OF SERVICES  
FOR HOSPITAL OR OUTPATIENT DIAGNOSTIC CENTER**

**1. NAME AND PHYSICAL ADDRESS OF FACILITY OF SERVICE**

Provider Type (Check One):  Hospital  Outpatient Diagnostic Center (ODC)

Henderson County Community Hospital

**Name**

200 West Church Street

**Address**

Lexington

TN

38351

**City**

**State**

**ZIP**

License Number: 58

**License Number:**

**2. CEO/ADMINISTRATOR OF PROVIDER**

Gary Stewart

CEO

**Name**

**Title**

Gary.stewart@henderson.health

**Email Address**

Henderson County Community Hospital

**Company Name**

200 West Church Street

**Address**

Lexington

TN

38311

**City**

**State**

**ZIP**

731-968-1897

**Phone Number**

**3. BILLING INFORMATION FOR FACILITY**

Shelley Taylor \_\_\_\_\_ Radiology Director  
Name Title

Shelley.taylor@henderson.health \_\_\_\_\_  
Email Address

Henderson County Community Hospital \_\_\_\_\_  
Company Name

200 West Church Street \_\_\_\_\_  
Address

Lexington \_\_\_\_\_ TN 38351  
City State ZIP

731-968-1833 \_\_\_\_\_  
Phone Number

On the following items, check all appropriate services to be licensed.

Have any of the following services been changed since the last occupancy approval or have had a Plans Review related to that service since the last approval?  Yes  No

If yes, what were the changes and date of changes?:

New magnet being installed February 2026. All drawings have been submitted and approved.

**ESTABLISHMENT OF A BURN UNIT:**

Physical Address of Service: \_\_\_\_\_

Number of Beds \_\_\_\_\_

What Age Group Will Be Served/Licensed?:  Pediatric  Adult  Both

Will the Burn Unit be Verified by ABA?:  Yes  No (Please attach documentation of verification.)

If no, why:

\_\_\_\_\_

**X ESTABLISHING MRI UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: 200 West Church Street

Name Brand of Unit Canon Vantage Orain

Tesla 1.5

Type (i.e. Close, Short Bore, etc.) Closed Bore

Unit's Serial Number SFB2552010

Will the MRI Unit be Accredited?:  Yes  No

If MRI Unit will be Accredited, is it  PENDING  ACCREDITED

If ACCREDITED, What Organization? DNV  
(Attach certificate or proof of accreditation.)

If no, why:

The MRI unit will be registered with the Health Facilities Commission.  Yes  No

**ESTABLISHING PET UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: \_\_\_\_\_

Name Brand of Unit \_\_\_\_\_

Type (i.e. PET Only, PET/CT, PET/MRI) \_\_\_\_\_

Unit's Serial Number \_\_\_\_\_

Will the PET Unit be Accredited?:  Yes  No

If PET Unit will be Accredited, is it  PENDING  ACCREDITED

If ACCREDITED, What Organization? \_\_\_\_\_  
(Attach certificate or proof of accreditation.)

If no, why:

The PET unit will be registered with the Health Facilities Commission.  Yes  No

**ESTABLISHING NEONATAL INTENSIVE CARE UNIT (NICU):**

**Physical Address of Service:** \_\_\_\_\_

**Choose Designation Type:**  **First Time Self Designation/Initial NICU License.**

**Designation at Different Level**

**What is the Current License  
Level of Care?** \_\_\_\_\_

**What is the Requested Level?** \_\_\_\_\_

**Ownership/Physical Location Change**

**Number of Beds by Each Level**

<b>Level II</b>	_____
<b>Level III</b>	_____
<b>Level III with Surgery</b>	_____
<b>Level IV</b>	_____

**Have you been evaluated by AAP?:**  **Yes**  **No**  
If yes, please provide documentation.

**Designate Expiration Date:** \_\_\_\_\_

**Neonatal Program Manager**

\_\_\_\_\_  
**Name** **Title**

\_\_\_\_\_  
**Email Address**

\_\_\_\_\_  
**Phone Number**

**Neonatal Medical Director**

\_\_\_\_\_  
**Name** **Title**

\_\_\_\_\_  
**Email Address**

\_\_\_\_\_  
**Phone Number**

Pursuant to Tennessee Rule of Civil Procedure 72, I hereby declare under perjury that the information provided in this application is true and correct. Signee for this 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 services for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated §68-11-201 and Rules 0720-.14, 0720-36, and 0720-47 adopted by the Commission effective December 1, 2025. 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.

Gary Stewart                      12/29/2025  
Signature                                      Date

Gary Stewart  
Printed Name



January 31, 2024

Gary Stewart  
Chief Executive Officer  
Lexington Hospital Corporation  
(d/b/a) Henderson County Community Hospital  
200 W Church St.  
Lexington, TN 38351

Program: Hospital  
CCN: 440008  
Survey Type: Medicare Recertification/DNV Reaccreditation  
Certificate #: 10000516355-MSC-CMS-USA  
Survey Dates: December 19-20, 2023  
Accreditation Decision: Full accreditation  
Date Acceptable Plan of Correction Received: 1/11/2024  
Method of Follow-up: Acceptable Plan of Correction,  
Self- Attestation, Document Review  
Effective Date of Accreditation: 2/8/2024  
Expiration Date of Accreditation: 2/8/2027  
Term of Accreditation: Three (3) years

Dear Mr. Stewart:

Pursuant to the authority granted to DNV Healthcare USA Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Lexington Hospital Corporation (d/b/a) Henderson County Community Hospital is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482) and awarded full accreditation for a three (3) year term effective on the date referenced above DNV Healthcare USA Inc. is recommending your organization for continued deemed status in the Medicare Program.

This accreditation is applicable to all facilities operating under the above-referenced CCN number at the following address(es):

Lexington Hospital Corporation (d/b/a) Henderson County Community Hospital - 200 W Church St. - Lexington, TN 38351

This accreditation also encompasses the swing beds in place and Lexington Hospital Corporation (d/b/a) Henderson County Community Hospital is deemed in compliance with the Medicare Conditions of Participation at (42 C.F.R. §482) to meet the special requirements for Hospital providers of long-term care services ("swing-beds").

This accreditation requires an annual survey and the organization's continual compliance with the DNVHC Accreditation Process. Failure to complete these actions or otherwise comply with your Management System Certification/Accreditation Agreement may result in a change in your organization's accreditation status.

Congratulations on this significant achievement.

Sincerely,

A handwritten signature in black ink, appearing to read "Kelly Proctor".

Kelly Proctor  
President

cc: CMS CO and CMS RO IV (Atlanta)