



**State of Tennessee
Health Facilities Commission**

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

**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)

Macon Hospital, Inc. d/b/a Macon Community Hospital

Name

305 West Locust Street

Address

Lafayette

TN

37083

City

State

ZIP

80

License Number:

2. CEO/ADMINISTRATOR OF PROVIDER

Scott A. Tongate

CEO

Name

Title

stongate@mcgh.net

Email Address

Macon Hospital, Inc. d/b/a Macon Community Hospital

Company Name

305 West Locust Street

Address

Lafayette

TN

37083

City

State

ZIP

615-666-2147

Phone Number

3. BILLING INFORMATION FOR FACILITY

Della Carter	AP & Payroll Coordinator	
Name	Title	
dcarter@mcgh.net		
Email Address		
Macon Hospital, Inc. d/b/a Macon Community Hospital		
Company Name		
PO Box 378		
Address		
Lafayette	TN	37083
City	State	ZIP
615-688-7924		
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?:

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:

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

Physical Address of Service: 305 West Locust Street, Lafayette, TN 37083

Name Brand of Unit GE

Tesla 1.5

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

Unit's Serial Number R3855

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

Level II	_____
Level III	_____
Level III with Surgery	_____
Level IV	_____

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.



Signature

11/24/2025

Date

Scott A. Tongate

Printed Name



HEALTHCARE CERTIFICATE

Certificate no.:
C627657

Initial certification date:
03 August, 2011

Valid:
03 August, 2023 – 03 August, 2026

This is to certify that the management system of

Macon Community Hospital

305 West Locust St., Lafayette, TN, 37083, USA

has been found to comply with the requirements of the:

NIAHO® Critical Access Hospital Accreditation Program

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, this organization is deemed in compliance with the Medicare Conditions of Participation for Specialized Providers – Critical Access Hospitals (42 C.F.R. §485 Subpart F).

Place and date:
Cincinnati, OH, 18 July, 2023



For the issuing office:
DNV Healthcare USA Inc.
4435 Aicholtz Road, Suite 900, Cincinnati,
OH, 45245, USA



Kelly Proctor
Management Representative