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 hsda.staff@tn.gov

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

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

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

LIVINGSTON REGIONAL HOSPITAL
Name

315 OAK STREET
Address

LIVINGSTON | TN | 38570
City | **State** | **ZIP**

92
License Number:

2. **CEO/ADMINISTRATOR OF PROVIDER**

LANCE MASON | CEO
Name | **Title**

Lance.Mason@scionhealth.com
Email Address

LIVINGSTON REGIONAL HOSPITAL
Company Name

315 OAK STREET
Address

LIVINGSTON | TN | 38570
City | **State** | **ZIP**

931-403-2102
Phone Number

3. **BILLING INFORMATION FOR FACILITY**

Jennifer Ledbetter — CFO
Name — Title

Invoices.sap@scionhealth.com / Jennifer.Ledbetter@scionhealth.com
Email Address

Livingston Regional Hospital
Company Name

PO Box 740054, / 315 Oak Street
Address

Louisville, KY 40201 / Livingston, TN 38570
City — State — ZIP

931-403-2102
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: 315 OAK STREET LIVINGSTON, TN 38570

Name Brand of Unit GE

Tesla 1.5

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

Unit's Serial Number 2UA0360C8L

Will the MRI Unit be Accredited?: ☑ Yes ☐ No

If MRI Unit will be Accredited, is it ☐ PENDING ☐ ACCREDITED

If ACCREDITED, What Organization? JOINT COMMISSION
(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

The Joint Commission

July 17, 2023

Tim McGill
CEO
Livingston Regional Hospital, LLC
315 Oak Street
Livingston, TN 38570

Joint Commission ID #: 7860
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 7/14/2023

Dear Mr. McGill:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning April 15, 2023, and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Deborah A Ryan

Deborah A. Ryan, MS, RN
Executive Vice President
Division of Accreditation and Certification Operations

☐ **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.

RT(R) 12-3-2025

Signature **Date**

TODD RADFORD RT(R)

Printed Name