



**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 hsdastaff@tn.gov

**INITIAL APPLICATION FOR LICENSE OF SERVICES  
FOR PHYSICIAN OFFICES**

**1. NAME AND PHYSICAL ADDRESS OF PHYSICIAN OFFICE OF SERVICE**

UMedical Care PLLC

Name

1500 W Elk Ave

Address

Elizabethton

TN

37043

City

State

ZIP

**2. CEO/ADMINISTRATOR OF PROVIDER**

Steve Hopland

CEO

Name

Title

shopland@medicalcareplc.com

Email Address

UMedical Care PLLC

Company Name

1500 W Elk Ave

Address

Elizabethton

TN

37043

City

State

ZIP

423-431-0527

Phone Number

3. **BILLING INFORMATION FOR FACILITY**

Name Wanda Larey Title Accounts Payable  
Email Address AP@medicalcarepllc.com  
Company Name Medical Care PLLC  
Address 1500 W. Elk Ave  
City Elizabethton State TN ZIP 37643  
Phone Number 423-431-0310

4. **OWNERSHIP OF FACILITY**

Name of Owner Medical Care PLLC  
Address 1500 W Elk Ave  
City Elizabethton State TN ZIP 37643  
Phone Number 423-431-0315

Legal Entity:

- Individual
- Limited Liability
- Corporation (For Profit)
- Corporation (Not for Profit)
- Government
- Limited Partnership
- Joint Venture
- Professional Limited Liability Company
- Other \_\_\_\_\_

List name(s) and addresses of individual owners, partners, directors of the corporation, or head of the government entity. (If more than two (2), please use ATTACHMENT - B.)

Kenneth Hopland  
(1) Name

1510 W Elk Ave  
Address

Elizabeth, TN 37643  
City State ZIP

Jeffery Hopland  
(2) Name

401 E Main St  
Address

Johnson City TN 37601  
City State ZIP

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

If no, why:

Is this facility chain affiliated?  Yes  No

If a corporation, is there a holding company?  Yes  No

If yes, please complete the following information of the holding company.

\_\_\_\_\_  
Name of Owner

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

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

Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states?  Yes  No

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

Is there a contract with a management firm to operate this facility?  Yes  No

If yes, please specify the dates of the contract and complete the firm's information.

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

\_\_\_\_\_  
Name of Firm

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

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

**5. LEGAL**

If any of the items within this section (LEGAL), please identify, explain, and provide documentation of the item(s) noted if response is "yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states listed, or the management firm listed been subjected to any of the following within the past five (5) years?

**Licensure**

- Denied a License  Yes  No
- Had a license suspended or revoked by any state licensure agency?  Yes  No
- Been subject to a final order or judgement in a state licensure action?  Yes  No

**Convictions**

- If convicted of a criminal offense related to that person's involvement in any program under any state or federal health care program – including Medicare, Medicaid, and TriCare?  Yes  No

Exclusion

➤ Excluded from participation in federal health care programs – Medicare, Medicaid, CHIP, or TriCare – in the past?  Yes  No

(Excluded is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare.)  Yes  No

Termination/Suspension

➤ Suspended or terminated from participation in Medicare or Medicaid/TennCare programs?  Yes  No

Fraud and Abuse

➤ Paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services?  Yes  No

Corporate Integrity Agreement

➤ Is presently an entity covered by and subject the terms of a corporate integrity agreement? (If yes, please provide a copy of CIA.)  Yes  No

Bankruptcy

➤ Filed bankruptcy under any provision of the United States Bankruptcy Code:  Yes  No

Civil Monetary Penalty (CMP)

➤ Paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than \$250,000 as a result of an enforcement action during a survey?  Yes  No

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

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

Physical Address of Service: 1500 W Elk Ave Elizabethton, TN 37643

Name Brand of Unit Toshiba Titan

Tesla 1.5T

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

Unit's Serial Number SN# 54A0922005

Will the MRI Unit be Accredited?:  Yes  No

If MRI Unit will be Accredited, is it  PENDING  ACCREDITED

If ACCREDITED, What Organization? \_\_\_\_\_  
(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

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.

Pamela Avey R.T.(R)(M) 3/26/2026  
Signature Date

Radiology Supervisor  
Title of Signee

Pamela Avey  
Printed Name

## Non-Refundable Licensing Fees for Listed Licensed Services

An invoice will be sent to the contact for Billing for total payment of fees.

### **MRI:**

Hospital: \$500 per MRI unit  
Outpatient Diagnostic Center: Included with ODC License  
Physician Office: \$500 per MRI unit

### **PET:**

Hospital: \$500 per MRI unit  
Outpatient Diagnostic Center: Included with ODC License  
Physician Office: \$500 per MRI unit

*(as of December 1, 2025)*



Medical Care PLLC

1500 W Elk  
Elizabethton, Tennessee 37643

was surveyed by the  
ACR Committee on MRI Accreditation  
of the Commission on Quality and Safety

The following magnet was approved  
Toshiba Corp. Vantage Titan 1.5T 2009

For  
Body, Breast, Head, MRA, MSK, Spine

Accredited from:  
June 05, 2023 through June 05, 2026

A handwritten signature in black ink, consisting of several stylized, overlapping strokes.

CHAIR, COMMITTEE ON MRI ACCREDITATION

A handwritten signature in black ink that reads "William T. Herrington MD".

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY