MISSISSIPPI STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH PLANNING AND RESOURCE DEVELOPMENT

Small Community Hospital Pilot Program
Determination of Reviewability (DR) Application Form
(Processing Fee: $2,500.00)

One (1) original DR application with the Certification Page must be mailed, or hand delivered to the Mississippi State Department of Health, and a complete ***copy*** of the application and attachments should be emailed to HPRD@msdh.ms.gov. Be sure to include the following words in the subject line of the e-mail: **DR application submission.** Please provide a Table of Contents referencing the Exhibits along with dividers or tabs to distinguish the appropriate Exhibit documentation.

Pursuant to the authority granted to the State Health Officer under the Small Community Hospital Pilot Program, enacted during the 2026 Regular Session of the Mississippi Legislature as 2026 Miss. Laws H.B. 1622 S.B. 2474, and HB 3 (2026 Miss. Legislative Session) codified at Miss. Code Ann. § 41-7-191 (2026), and related authority under Miss. Code Ann. § 41-7-171 et seq., the Mississippi State Department of Health hereby issues this CON Exemption Service License as follows:

(1) Exemption for rural hospital's main building campus as constituted on January 1, 2026, and any approved location(s) within a five (5) mile radius of the hospital's main building campus, consistent with statutory requirements.

a. Such exemption shall not extend to clinics or other facilities owned or operated by the rural hospital that are not located on the main campus of the rural hospital.

b. Such exemption shall not apply to services for which there is a general certificate of need moratorium.

c. Such exemption shall not apply to applications for a certificate of need that would place the licensed hospital receiving the exemption within thirty-five (35) miles of another licensed hospital or otherwise jeopardize a licensed hospital's federal critical access hospital designation.

(2) Exemption for facilities located in the Delta Public Health Region. This exemption may be applied to a capital expenditure or service line addition that would otherwise require a CON. The opportunity to apply under this exemption expires on June 30, 2027.

a. A licensed critical access hospital (CAH), as designated by the federal Centers for Medicare and Medicaid Services on or before the effective date of this act;

b. A licensed general acute care hospital in Bolivar, Coahoma, Holmes, Issaquena, Leflore, Quitman, Sunflower, Tallahatchie, Tate, Washington or Yazoo counties; or

c. A licensed general acute care hospital located in a municipality with a population of less than fifteen thousand (15,000) persons as provided by the 2020 Census conducted by the United State Census Bureau, excluding any such hospital located in a metropolitan statistical area as designated by the federal Office of Management and Budget unless such hospital otherwise meets the definition of a rural hospital.

The original application including attachments and filing fee should be mailed or hand delivered to the following address:

Division of Health Planning and Resource Development
Mississippi State Department of Health - Office of Health Protection
143-B Le Fleur's Square
Jackson, MS 39211

Note: (CONFIDENTIAL Information)
If the CON Application contains information deemed CONFIDENTIAL, please submit a statement (*the statement must provide an explanation as to why the applicant considers the information specified to be deemed CONFIDENTIAL*); clarifying why the allocated information is deemed CONFIDENTIAL.

CONFIDENTIAL information must be submitted under a separate cover, isolated from the CON application.

I. Project Information (All Projects)

1. Title of Project: _____

2. Type of Facility: _____Hospital _____Nursing Home _____Freestanding ASC _____Other (If Other Please Specify):

3. (If a single specialty ambulatory surgery center): Please state specialty: _____

II. Facility/Applicant Information (All Projects)

1. Facility name, address, city, county, zip code.

2. Legal name and address of the applicant, if different from information allocated above.

3. Principal agent to contact for this project (Include address, city, county, zip code, email and telephone number).

4. Type of organization (e.g., county-owned, not-for-profit acute care hospital).

5. Provide evidence that the entity proposing to provide the service is authorized to do business in the State of Mississippi.

III. Project Description (All Projects)

1. Provide a brief narrative description of the project or proposed facility, including types of services currently offered, type of surgery that will be performed (if applicable), location of new construction, areas involved in repair or renovation, square feet involved in new construction or renovation, new services being proposed, and/or equipment acquisition proposed.

2. If the proposed project involves relocation, please state the distance between the current/existing facility and the proposed facility.

3. Provide documentation that a hospital is not within a 35-mile radius of your hospital.

4. Provide the population (provided by the 2020 United States Census).

5. Is the facility currently operational and serving patients?

6. What days of the week and time will the facility be operating?

7. Please submit the following:
   - Architect's schematic drawings.
   - Site approval from the Division of Fire Safety and Construction, Bureau of Health Facilities Licensure and Certification.
   - Building/Facility Lease Agreement (*if applicable)*
   - Building/Facility Purchase Agreement *(if applicable)*
   - Construction cost estimate *(signed from a MS licensed architect or a contractor authorized to do business in Mississippi., if applicable)*

8. If new construction is being developed by an entity other than the applicant,

   a. Identify owners/Board of Directors and enclose charters of incorporation or partnership agreement, etc.

   b. Identify tenants that will occupy the building, if applicable.

   c. Will the facility share the same parking lot as the hospital.

9. Estimated project cost:

a. Construction Cost – New _____

b. Construction Cost – Renovation _____

c. Capital Improvement Cost (i.e., minor painting and repairs, refurbishing) _____

d. Total Fixed Equipment Cost _____

e. Total Non-Fixed Equipment Cost _____

f. Land Cost _____

g. Site Preparation Cost _____

h. Fees (architectural, consultant, etc.) _____

i. Contingency Reserve _____

j. Capitalized Interest _____

k. Other Costs (specify) _____ _____

l. Total Estimated Project Cost _____

10. If the project involves purchase/lease of equipment, provide the following:

    a. A copy of the proposed vendor contract, including lease amount, if applicable.

    b. Assurance that the entity desiring to acquire or otherwise control the equipment is a registered business entity authorized to do business in Mississippi.

    c. Name of proposed health care facility or facilities to be served, if mobile or shared unit. Include a copy of proposed vendor service contract.

    d. In addition, if the proposed project does not involve new equipment, provide independent report on the fair market value of the major medical equipment, such as:

       Original purchase price of equipment
       Purchase and installation date (s) of equipment
       Depreciation schedule of equipment
       Fair market value of equipment.

11. Anticipated purchase and installation date(s) for equipment/service.

IV. Sign the attached Certification Page (ALL PROJECTS)

CERTIFICATION

STATE OF MISSISSIPPI
COUNTY OF

I (we) do solemnly swear or affirm on behalf of _____ _____, after diligent research, inquiry and study, that the information and material contained in this foregoing application for a Declaratory Ruling is true, accurate, and correct, to the best of my (our) knowledge and belief. I (we) understand that the Mississippi State Department of Health will rely on this information and material in making its determination and if it finds that the application contains distorted facts or misrepresentation, the Department may require Certificate of Need review of the project. I (we) will notify the Department should subsequent increases in the cost of any portion of this project cause the capital expenditure to exceed $3,000,000.00for equipment, $10,000,000.00 for clinical health services and/or $20,000,000.00 for non-clinical health services, and will apply for a CON.

It is further understood that this determination ruling is valid for a period of twelve (12) months. If the project is not implemented within the twelve-month period, I (we) must request a second ruling by the Department. I (we) understand that if the statute or Plan changes during a twelve (12)-month period in which the proposed project is not implemented, the Department will make its determination ruling in accordance with the proposed statute/Plan change.

_____ _____
Signature Signature

_____ _____
Title Title

_____
Name of Facility

Sworn to and subscribed before me, this the _____ day of _____, 20 ____.

_____
Notary Public

_____
My Commission