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Sharkey-Issaquena Community Hospital

Transforming Rural Healthcare

Rolling Fork and Sharkey County, Mississippi

Planning Document Research

CDBG-DR

FEMA-4697-DR, FEMA-4727-DR, and FEMA-4790-DR

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A Note to the Reader

This document is provided as a prototype concept to examine the feasibility of the rebuilding of the Sharkey-Issaquena Community Hospital that was destroyed by a tornado in 2023. This study contains forward-looking statements and projections provided for informational and illustrative purposes only and are not guarantees of future performance. Projections and estimates represent only current assumptions regarding future events, many of which are outside the control of the authors. This study does not constitute financial, legal, or investment advice. Multiple changes may occur as the planning process for this hospital continues. Changes may include total square footage, building configuration and amenities, and final construction costs. Costs, sources of financing, and the structure of the financing for this project may also be subject to change. The reader acknowledges the inherent uncertainties of such data and assumes responsibility for its use.

The Sharkey-Issaquena Community Hospital: a 29-Bed Acute Care Rural Hospital with Integrated Healthcare Medical Mall and Adjacent 30-Room Extended Stay Hotel

A Comprehensive Plan for a Modern Rural Healthcare Facility Featuring Mall-Style Integration of Health Care Services combined with a 30-bed extended-stay motel to meet the needs of hospital visitors, business travelers, visiting healthcare providers, and tourists.

Imagine arriving in a welcoming rural community, where a state-of-the-art, 29-bed acute care hospital seamlessly connects health services, patient comfort, and community engagement. As you step through the main entrance, you are greeted by a light-filled lobby that not only provides access to the latest in acute medical care but also opens into a vibrant healthcare mall. Here, ten thoughtfully curated storefronts offer everything from physical therapy and pharmacy services to eye care, each accessible both from the outside for local residents and from the hospital's central corridor, making care truly convenient.

Next door, a 30-room extended-stay hotel welcomes visiting families, traveling healthcare professionals, business visitors, and tourists. Hotel guests enjoy direct access to amenities like a full-service restaurant and a well-equipped workout center, both open to the public and designed to serve the broader community. This innovative development is not just a health facility, it is a hub of activity, care, and connection, built to enhance rural life while ensuring financial stability through diverse revenue streams and strategic partnerships. With every detail, this facility stands as a model for modern rural healthcare—integrated, accessible, and community-focused.

Financed using a strategic public-private partnership investment structure using both federal and Mississippi state NMTC programs, the project leverages multiple sources of funding and minimizes investment risk. Importantly, additional sources of funding may include:

- **EDA-Disaster-2025 FY Disaster Supplemental Grants**
- **CDBG-DR Grant Funds**
- **Governor Reeves' Mississippi Rural Health Transformation Program Funding**

ENHANCED PROJECT FEASIBILITY IN A HIGH-POVERTY AREA CREATING 140+ JOBS WHILE IMPROVING ACCESS TO HIGH QUALITY RURAL HEALTHCARE AND EXPANDING THE RURAL HEALTHCARE WORKFORCE. GRANT FUNDING REDUCES THE COST OF ENTRY FOR PHYSICIANS AND HEALTHCARE PROVIDERS TO LEASE FLEXIBLE OFFICE SPACE ADJACENT TO HOSPITALS IN RURAL COMMUNITIES.

Executive Summary

Mission: To deliver high-quality, accessible critical care to Sharkey County's residents, focusing on emergency response, chronic disease management, and preventive care in a high-poverty, medically underserved area (MUA).

Competitive Landscape: Nearest full-service hospitals are 35+ miles away in Vicksburg or Greenville. Sharkey-Issaquena Community Hospital will differentiate through telehealth integrations, medical mall retail flex office space for healthcare practitioners, community outreach, and partnerships with regional networks for referrals.

This business plan outlines the establishment and operation of Sharkey-Issaquena Community Hospital, a 29-bed Critical Access Hospital (CAH) in Sharkey County, Mississippi. The proposed project replaces the 29-bed Critical Access Hospital Sharkey-Issaquena Community Hospital, formerly located at 47 North 4th Street in Rolling Fork, Mississippi that was destroyed by a tornado associated with FEMA 4697-DR, a Presidentially declared disaster. The project consists of a new construction with the following components:

- A 60,000 square foot critical access hospital augmented with telemedicine infrastructure.
- 25,000 square feet of medical retail storefronts offering an array of healthcare provider flex office space.
- A 15,000 square foot 30-room extended stay hotel with community accessible fitness center.
- Shared restaurant and cafeteria facilities to serve hotel guests, hospital patients and staff, patient visitors, and travelers.
- Project hard costs are estimated at $56 million ($46 million for the 29-bed hospital with 10 medical mall storefronts, $5 million for hotel, and $5 million for infrastructure); including additional soft costs of an estimated $14 million would bring the total cost to $70 million.

Located in a rural, underserved area with a population of approximately 3,500 residents, the hospital will provide essential critical care services, including 24/7 emergency care, inpatient acute care, and outpatient services. The hospital has CAH designation to qualify for cost-based Medicare reimbursement, addressing the high Medicare and Medicaid payer mix in the region. Key objectives include improving local healthcare access, reducing patient transfers to distant facilities, and achieving financial sustainability through efficient operations and community partnerships.

Company Description: Sharkey-Issaquena Community Hospital is currently a nonprofit, county-owned or community-governed CAH located in Rolling Fork, Mississippi, the county seat of Sharkey County. The facility will feature 29 acute care beds, with flexibility for swing beds to

support skilled nursing needs. As a CAH, it will maintain an average inpatient stay of no more than 96 hours and provide 24/7 emergency services.

Legal Structure: Nonprofit entity, eligible for CAH designation under Mississippi Code § 41-9-209, requiring state approval and compliance with federal CMS standards (e.g., rural location >35 miles from nearest hospital or necessary provider status).

Organization and Management: Sharkey-Issaquena Community Hospital will be governed by a 7-member board including county officials, physicians, and community leaders.

Management team:[1, 2]

- CEO/Hospital Administrator: Oversees operations; average MS salary $104,441.
- Chief Medical Officer: Physician leadership; average MS physician salary $234,000.
- Chief Nursing Officer: Nurse administration; average MS salary $79,870.
- CFO and Support Staff: Finance, Human Resource, Information Technology.

Staffing:

- Approximately 76 full-time equivalents (FTEs). Note: this is lower than the Mississippi Critical Access Hospital average of 127 FTEs for 29-bed facilities.
- Assumptions include:[3] 40% nursing (RNs $64,532 avg, LPNs estimated at $38/hr.), 20% physicians/APRNs ($95k+), 40% support/technical.[4]

Market Overview:[5]

- Sharkey County has a population of about 3,234 (2024 estimate), with 73.7% Black/African American residents and a median household income of $22,609—well below state ($52,985) and national ($75,149) averages. Poverty affects 27.3% to 35.1% of residents, with 54.3% of children under 18 in poverty.
- Health insurance coverage is 85.8%, but 20.3% lack coverage, with heavy reliance on Medicaid (33.2%) and Medicare (13.1%).
- The county is federally designated as an MUA, with poor health outcomes (e.g., high rates of diabetes, heart disease) and limited access to care.
- Sharkey County is experiencing increasing health care needs by an aging population with approximately 25.2 % of the population over the age of 60.

[1] Sources: Mississippi State Department of Health: Mississippi Rural Health Plan 2022 https://msdh.ms.gov/page/resources/66.pdf
[2] CAH Financial Indicators Report: Summary of Indicator Medians by State April 2024: Flex Monitoring Team https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/state-medians-2022data_report-final_2024.pdf
[3] Ibid.
[4] RNtoMSNedu.org. Salaries for MSN-Educated Nurses in Mississippi https://www.rntomsnedu.org/mississippi/mississippi-salary/
[5] U.S. Census www.census.gov.www.census.gov and Data Commons https://datacommons.org/place/geoId/28125

- Demand is driven by rural isolation, physician shortages (Mississippi has the worst ratio nationally at 180.8 per 100,000), and high uncompensated care (median 5.53% of expenses for MS CAHs).
- Approximately 49.8% of the population is obese.

Services Offered:

- In-patient: 29 acute care beds for critical conditions (e.g., trauma, cardiac, respiratory).
- Emergency: 24/7 ER with on-call physicians.
- Outpatient: Clinics for primary care, diagnostics (lab, x-ray), telehealth.
- Ancillary: Swing beds for post-acute care, community health programs.
- Compliance: Meet CMS CAH requirements, including network agreements for transfers and quality assurance.

SWOT Analysis:

- Strengths: CAH reimbursement (101% of costs for Medicare), local focus.
- Weaknesses: Low payer reimbursements, high uncompensated care.
- Opportunities: federal FLEX/SHIP grants. EDA-Disaster-2025 FY Disaster Supplemental Grants, CDBG-DR Grant Funds, Governor Reeves' Mississippi Rural Health Transformation Program Funding
- Threats: Rising costs, workforce shortages, potential closures (49% of MS rural hospitals at-risk).

Community Outreach Strategy:

- Target Audience: Local residents, especially low-income and elderly. Community outreach: Health fairs, partnerships with schools/churches.
- Digital: Website, social media for education.
- Referral Networks: Collaborate with regional hospitals for specialty care.
- Payer Focus: Maximize Medicare (75.72% median payer mix in MS CAHs) and Medicaid (10.83%).
- Budget: $150,000 annually for marketing.

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Introduction

This architectural design plan details a 29-bed acute care hospital featuring a unique integrated mall-style layout on the first floor. The facility is designed to enhance patient and visitor experience by housing 10 healthcare-related storefronts leased to health care service and product providers, with dual access points—external entrances for public convenience and internal entrances from a central corridor for seamless hospital integration.

A restaurant serves hotel guests, hospital visitors, and staff, and is open to the public. This maximizes capacity utilization for the full-service kitchen that prepares patient meals and creates additional revenue opportunities as a lease or to enhance internal income.

The Workout Center located in the 30-room extended stay hotel with dual access points for easy internal access from the hotel also provides external access to local members. The Workout Center provides the opportunity to generate income from leasing the space to a small business lease opportunity or to generate membership revenue to the CDE.

The $70 million project ($56 million in hard costs +$14 million soft costs) uses a structured twinned New Market Tax Credit leverage model with $40 million of federal and $16 million of state NMTC allocations; providing a new subsidy of $16.6 million (24% of costs).

The project creates multiple sources of operating revenue flow including: patient revenue from hospital services, lease/rental revenue from medical retail storefronts, hotel room revenue, hotel room “condo-ownership” fees/leases from visiting health care providers, lease or operating income from the restaurant, and lease or operating income from the workout center located in the extended-stay hotel.

Site Plan

The hospital is situated on a rectangular lot with dimensions allowing for optimal building footprint and site circulation. The main vehicular entrance is positioned on the north side, leading directly to a drop-off zone at the central hospital lobby. Dedicated parking is provided as follows:

- Staff Parking: 50 spaces (east side)
- Visitor Parking: 65 spaces (west and south sides)
- Accessible Parking: 6 spaces adjacent to the main entrance

Emergency and service vehicle access is located on the southeast corner, with a dedicated ambulance bay and loading dock. Pedestrian walkways connect all parking areas to the main hospital and the external storefront entrances. All sidewalks and building entrances are accessible.

First Floor Plan: Mall-Style Corridor and Storefronts

The first floor is organized around a central, 12-foot-wide mall-style corridor stretching east–west, serving as the primary internal circulation spine. Ten healthcare storefronts are arrayed along the corridor, five per side, each with the following features:

- External Entrance: Direct access from the building exterior, weather-protected, with illuminated signage
- Internal Entrance: Secure connection to the central corridor for patient and staff movement
- Standard Storefront Size: Each unit is approximately 2,500 sq ft (20 to 30 ft. frontage), with flexible partitioning for specialty requirements.

The storefronts are designated for:

1. Primary Care Physician
2. Dentist
3. Optician
4. Ophthalmologist
5. Pharmacy/Druggist
6. Pediatrics
7. Physical Therapy
8. Imaging Services (e.g., X-ray, Ultrasound)
9. Specialist Clinic (e.g., Cardiology, Dialysis)
10. Family Practice Physician

A shared waiting area is located at the center of the corridor, with individual sub-waiting spaces adjacent to each storefront. Public restrooms and a central reception/information desk are positioned near the main hospital entrance.

Hospital Bed Area: 29-Bed Ward Layout

The inpatient area is located on the second floor, directly above the mall-style corridor for efficient vertical circulation. The ward is organized as follows:

- Bed Units: 29 private rooms, each 180 sq ft (12 ft x 15 ft), with en-suite ADA-compliant bathrooms, natural light, and patient/family seating.
- Nurse Stations: Two decentralized stations (one per 11 rooms), located for optimal line-of-sight and accessibility.
- Support Spaces: Medication room, clean and soiled utility, staff lounge, storage, and linen supply rooms.
- Family Lounge: Overlooks landscaped courtyard for respite and waiting.

Circulation and Accessibility

The facility ensures clear, unobstructed circulation and full ADA compliance:

- Corridors: Main corridor (12 ft wide), secondary corridors (8 ft wide) for staff/service traffic
- Vertical Circulation: Two passenger elevators (one public, one staff/service), plus two stairwells at opposite ends of the corridor.
- Entrances: All entrances are step-free and feature automatic doors; accessible routes connect all areas including parking and restrooms
- Wayfinding: Clear signage, color-coded zones, and tactile indicators throughout

Support Services

Essential hospital support services are distributed for operational efficiency:

- Pharmacy: Located adjacent to both the mall corridor (public access) and hospital core (staff access)
- Imaging Suite: On first floor, with direct access from both the storefront and hospital emergency/ambulatory area
- Laboratory: Centrally located for both inpatient and outpatient specimen collection
- Administration: Offices, conference room, and medical records on the mezzanine level above the mall corridor
- Food Services: Staff and visitor cafeteria with indoor and outdoor seating, adjacent to the main lobby Commercial kitchen with multi-building accessibility to serve hospital and hotel.

Exterior Elevations

The exterior design features a contemporary aesthetic with durable, low-maintenance materials:

- Storefront Facades: Glass and aluminum curtain walls with prominent canopies, distinct signage for each provider, and integrated lighting for visibility
- Main Hospital Entrance: Double-height glass vestibule with covered drop-off zone, clear branding, and landscaping elements
- Emergency Entrance: Canopied, visible from main access road, with direct route to imaging and inpatient floors

Summary: Key Design Features and Rationale

- Integrated Mall-Style Layout: Enhances accessibility, convenience, and cross-referral opportunities by co-locating diverse healthcare providers.
- Dual Entrances for Storefronts: Facilitates both walk-in public access and internal hospital connectivity, supporting flexible hours and efficient workflows.
- Efficient Inpatient Care: Compact 29-bed ward with decentralized nurse stations and support spaces ensures high-quality, patient-centered care.
- ADA-Compliant Circulation: Wide corridors, accessible entrances, and wayfinding support universal access for all users.
- Distinctive Exterior Identity: Modern facades and clear signage reinforce the hospital's role as a community health destination.

This architectural plan provides a functional, flexible, and future-ready template for a 29-bed hospital with an integrated healthcare mall, supporting both clinical excellence and patient-centered service. In addition to patient rooms and an operating room, essential spaces in this small, 29-bed hospital include areas for diagnostic services, support functions, staff welfare, and public access.

Planning Considerations

Clinical and Diagnostic Areas

- Emergency Department (ED): Even in a small hospital, an area for handling acute, unplanned health problems is necessary. This would include a triage area and treatment rooms/bays.
- Imaging Facilities (Radiology): Space for diagnostic imaging services, such as X-rays or potentially a CT scan, is crucial for timely diagnosis.
- Laboratory (Pathology): A small pathology lab or an area for collecting samples and performing basic tests is needed to support clinical decision-making.
- Pharmacy: A dedicated space for dispensing medications and managing pharmaceutical supplies.
- Treatment/Exam Rooms: Separate rooms for outpatient consultations and minor procedures.
- Intensive Care Unit (ICU): Depending on the scope of services, a small number of beds or a specific area for critically ill patients needing close monitoring may be required.

Support Services and Operations

- Sterile Processing/Clean Workroom: A dedicated area for cleaning, sterilizing, and storing surgical instruments and medical equipment to ensure infection control.
- Soiled Workroom: A separate space for handling contaminated materials and waste before disposal or processing.
- Storage Rooms: Ample storage for medical supplies, linens, and equipment is vital for efficient operations.
- Biomedical Waste Zone: A specific, isolated area for managing hazardous waste according to regulations.
- Housekeeping/Environmental Services: A janitorial room and space for housekeeping supplies.
- Dietary/Kitchen Area: Facilities for preparing patient meals, which may range from a small kitchenette to a full-service kitchen, depending on the hospital's model.
- Loading Dock/Supply Chain Area: For receiving deliveries of medical supplies, food, and other goods.

Staff and Administrative Areas

- Nurse Stations: Centrally located stations in each patient care area for monitoring patients, charting, and coordination.
- On-Call Rooms: Rooms where physicians and staff can rest during long shifts.
- Staff Lounges/Break Areas: Dedicated spaces for staff to take breaks and decompress to improve well-being and reduce fatigue.
- Offices: Private or shared offices for the hospital manager, administrators, and other key personnel.
- Meeting/Training Rooms: Space for staff meetings, training sessions, and consultations.
- Locker/Changing Rooms: Areas for staff to change into and store their uniforms or attire.

Public Areas and Amenities

- Main Lobby and Reception: A welcoming entrance with a clear check-in area.
- Waiting Areas: Comfortable waiting spaces for patients and their families in various departments (e.g., ED, lab, imaging).
- Public Restrooms: Easily accessible and ADA-compliant restrooms.
- Family/Visitor Areas: Small lounges or areas within patient units for visitors' comfort.

Medical Retail Space

Medical retail spaces have gained popularity due to their inherent advantages: high visibility, convenient access, ample parking, and proximity to residential areas. These locations allow healthcare providers to integrate their services into patients’ daily routines, leading to increased foot traffic and improved patient satisfaction. However, each medical practice type has distinct space requirements and considerations that must be carefully evaluated during the site selection process.

The space should be designed for streamlined patient movement, ideally with separate entrances and exits in high-volume locations. Infrastructure requirements include enhanced HVAC systems (for air filtration and infection control), sufficient power capacity for diagnostic equipment, and potential accommodations for medical gases if the facility provides moderate sedation or oxygen therapy. The layout must ensure a clear separation between waiting and treatment areas to maintain patient privacy and meet HIPAA compliance standards.

Primary Care Practices

Primary care offices typically require 2,000 to 6,000 square feet and must balance efficiency with patient comfort. These spaces need to accommodate steady patient flow while maintaining privacy as well as a professional atmosphere. Locations near residential areas are ideal for capturing and maintaining a regular patient base.

The layout should provide clear separation between waiting and clinical areas, with multiple examination rooms for efficient patient rotation. Space for laboratory services and basic diagnostic procedures is essential. Secure areas for medical records and supplies must be incorporated into the design. Enhanced HVAC systems for infection control and adequate sound insulation between examination rooms are necessary for maintaining professional standards and patient privacy.

Dental Practices

Dental practices require highly specialized spaces with specific technical requirements. These offices typically need 1,800 to 5,000 square feet, depending on the number of operatories. The floor structure must support heavy equipment loads, while enhanced electrical systems are necessary for dental chairs and imaging equipment. Specialized plumbing for dental units and sterilization is essential, as are lead-lined walls for X-ray rooms. Sound attenuation between dental stations is crucial for patient comfort and privacy. Complex HVAC systems must be installed for proper air handling and sterilization requirements. Additionally, all doorways and corridors must be ADA-compliant and wide enough to accommodate dental equipment installation and patient movement.

Specialized Medical Practices

Medical retail spaces must often accommodate specialized practices with unique requirements. Imaging centers require substantial space, typically 3,000 to 7,000 square feet, with enhanced structural support for heavy equipment. These facilities need specialized electrical and cooling systems, along with lead-lined walls for radiation protection. Wide corridors and doorways are essential for equipment installation and maintenance.

Physical Therapy Offices

Physical therapy offices favor open-floor plans ranging from 2,500 to 5,000 square feet to accommodate exercise equipment and movement areas. These spaces require high ceilings and reinforced floors, along with

private treatment rooms for individual patient care. Proper ventilation is crucial in exercise areas to maintain comfort and hygiene standards.

Optometry Practices

Optometry practices generally occupy 1,800 to 3,500 square feet and require careful attention to lighting control. The space must balance retail display areas for frames with clinical space for examinations. Multiple examination rooms with specialized equipment power requirements are standard, and the layout should facilitate smooth patient flow between retail and clinical areas.

Critical Infrastructure Considerations

The power requirements for medical retail spaces are substantially more complex than traditional retail. Dedicated circuits for medical equipment are essential, along with emergency backup systems and surge protection. Multiple electrical panels are often necessary, and many practices require generator connectivity options for critical systems.

HVAC systems in medical retail spaces must meet stringent standards for air quality and control. Enhanced air filtration and humidity control are essential for maintaining a sterile environment. Specialized ventilation for medical areas and temperature zoning capabilities helps maintain comfort while meeting medical requirements. These systems play a crucial role in infection control measures.

Plumbing systems must accommodate medical-specific needs, including medical gas infrastructure and enhanced water filtration. Multiple sink locations throughout the space are necessary for maintaining hygiene standards. Floor drains in specific areas and emergency shut-off systems are important safety features that must be incorporated into the design.

Compliance and Regulatory Requirements for Medical Retail Space

Medical retail spaces must adhere to a complex web of regulatory requirements. ADA compliance extends beyond basic accessibility to include specific medical facility standards. The layout must support HIPAA compliance through appropriate sound insulation and patient privacy measures. Local health department regulations often dictate specific design elements and operational procedures.

Medical waste handling requires specialized facilities and protocols, while fire safety and emergency evacuation requirements may be more stringent than in traditional retail spaces. Building codes for medical uses often include additional requirements for ventilation, electrical systems, and structural elements that must be addressed during the planning phase.

Lease Considerations

Medical leases typically extend longer than traditional retail agreements, usually ranging from seven to ten years. This longer term reflects the substantial investment in specialized buildouts, the time required to establish a patient base, and the complexity of equipment installation. The extended timeline also allows practices to achieve a reasonable return on their investment in the space.

Tenant improvement negotiations are particularly critical for medical spaces. The allowance must account for specialized construction requirements and equipment installation needs. Permit acquisition often takes longer for medical facilities, and construction timelines should include contingencies for unexpected issues that may arise during the build-out process.

Operating expenses in medical retail spaces typically exceed those of traditional retail due to higher utility costs for medical equipment and specialized maintenance requirements. Medical waste disposal and enhanced cleaning services add to these costs. Insurance requirements are also typically higher, reflecting the increased complexity and risk associated with medical operations.

Successful medical retail spaces require thorough location analysis that goes beyond traditional retail metrics. The demographic profile must align precisely with the target patient base, while parking ratios typically need to accommodate five to seven spaces per 1,000 square feet. Easy access from major roads and prominent visibility with signage opportunities are essential for capturing patient traffic.

The proximity to complementary medical services can create valuable synergies, but competition analysis within the trade area must be carefully considered. Understanding the existing medical service landscape helps practices position themselves effectively within the market while avoiding oversaturation.

Projected Construction Costs

- Integrated design savings. Medical retail on ground floor integrated with the hospital and hotel shares infrastructure (e.g., utilities, entrances, parking spaces). Cost savings of 5% to 15% due to shared walls, roofs, and HVAC systems.
- Hospital dominates costs. The acute care facilities cost far more per square foot than retail/hotels due to the need for specialized MEP (medical gas, sterile environments, backup power), code requirements, and infection control.

Table 1: Project Cost Elements

Component	Estimate Size (sq. ft.)	Explanation
29-Bed Hospital	60,000	Small hospitals (under 100 beds) average under 200,000 sq ft total, but for 29 beds, this scales to ± 2,100 sq ft per bed including ER, ORs, admin, and patient rooms (120-140 sq ft each).[1]
10 Healthcare Storefronts	25,000	Each storefront approximately 2,500 sq ft (suitable for a small clinic with exam rooms, reception, and storage). Medical offices typically need 1,000-1,500 sq ft per provider, but storefronts allow for multi-provider flexible setups. [2]
30-Room Extended Stay Hotel	15,000	Rooms average 365-400 sq ft each (with kitchenettes), plus 50% for common areas (lobby, laundry, fitness). Total approximately 600 sq ft per room. [3]
Total (with shared spaces)	**100,000**	**Includes overlaps for efficiency in a mall format.**

Sources:

(1) Definitive Healthcare https://www.definitivehc.com/resources/healthcare-insights/average-us-hospital-square-footage

(2) Medical Group Management Association https://www.mgma.com/articles/size-matters-in-medical-practice-space-selection

(3) Aquila https://aquilacommercial.com/about-aquila/case-studies/

(4) SiteMinderhttps://www.siteminder.com/r/hotel-room-sizes/

(5) myviciniti.com/corporate-housing-vs-hotels

Project Hard Cost Breakdown

Component	Cost per Sq Ft / Room	Estimated Total Cost	Rationale
29-Bed Hospital	60,000 sq. ft. @ $600/sq ft	$36 million	Healthcare facilities range $450-1,020 / sq ft, with new builds averaging $700-730 / sq ft nationally. Emergency-focused hospitals fall $200-500 / sq ft, JP averaged for a full-service setup.
10 Healthcare Storefronts	25,000 sq. ft. @ $400/sq ft	$10 million	Medical offices average $375-1,018 / sq ft for new builds, or $150-300 for buildouts. JP used a mid-range for standalone-quality spaces.
30-Room Extended Stay Hotel	$160,000 / room (or approximately $320 / sq ft)	$5 million	Extended-stay hotels median $150,000-250,000 / room for select-service/mid-scale. Per sq ft: $212-550 for 3-star equivalents. JP averaged for mid-tier with kitchenettes.
Site Work & Shared Infrastructure (e.g., parking, utilities, landscaping)	$50 / sq ft (applied to total)	$5 million	Typically, 10-15% of project cost for grading, parking (4-5 spaces/1,000 sq ft), and utilities tie-ins.
Total Estimated Construction Cost	**N/A**	**$56 million**	**Rounded up for contingencies. Per sq ft overall: approximately $560.**

Soft Costs Breakdown

Soft costs refer to indirect expenses not tied to physical construction (e.g., materials and labor), such as professional fees, permits, and contingencies. For healthcare projects, soft costs typically range from 20-30% of the total project budget, which includes both hard and soft costs. Calculating the soft costs in addition to the hard costs (the $56 million construction estimate described in the previous paragraphs). Based on industry data for healthcare and commercial facilities, we use a mid-range addition of 25% to hard costs, equaling approximately $14 million in soft costs—bringing the total project cost to around $70 million (excluding land, FF&E like medical equipment or operations).

Recognizing that these costs may vary by location, project complexity, and regulations (e.g., higher for urban sites with stringent healthcare codes). The breakdown below is based on typical proportions for healthcare construction projects, drawn from aggregated industry sources. Percentages are approximate and applied to the $56 million hard costs for estimation. Actuals numbers would require detailed bids.

Table 2: Soft Costs for Hospital-Medical Mall-Extended Stay Project

Category	Description	Estimated % of Hard Costs	Estimated Cost	Rationale
Architectural & Engineering Fees	Fees for architects, engineers, and consultants (e.g., structural, mechanical, electrical for medical-grade systems). Includes design, feasibility studies, and compliance with healthcare standards like HIPAA and infection control.	8%	$4.48 million	Common range: 5-10% for complex projects like hospitals; lower for simpler commercial spaces.
Permits & Regulatory Fees	Building permits, zoning approvals, environmental assessments, surveys, and healthcare-specific certifications (e.g., state health department reviews).	2%	$1.12 million	Typically, 1% to 3% higher for medical facilities due to added inspections and compliance.
Legal & Accounting Fees	Attorney fees for contracts, land titling, and financing; accounting for budgeting and audits.	1.50%	$0.84 million	Around 1% to 2%; includes borrower/lender legal for loans.
Insurance	Builder's risk, liability, workers' compensation, and professional liability insurance.	1.50%	$0.84 million	1% to 2%; often based on total project value and risk factors like medical operations.
Contingencies	Reserve for unforeseen issues, such as design changes, delays, or material price fluctuations.	7%	$3.92 million	Standard 5% to 10%; recommended higher for integrated facilities with hotel and retail elements.
Financing Costs	Loan origination, interest during construction, and commitment fees.	3%	$1.68 million	2% to 3%; depends on loan size and duration (e.g., 18-24 months build time).
Project Management & Administrative	Fees for project managers, administrative staff, temporary utilities, and oversight.	4%	$2.24 million	2% to 5%; includes coordination for multi-use aspects like hospital-hotel integration.
Environmental, Surveys & Miscellaneous	Site surveys, geotechnical studies, marketing for storefront leasing, and public relations.	1% (each sub-item)	$0.56 million (combined)	1$ to 2% total; essential for site prep and community buy-in.
Total Soft Costs		**25%**	**$14 million**	**Aggregated estimate; adjust based on specifics.**

Structured New Markets Tax Credit (NMTC) Investment for the Project

This outlines a proposed $70 million project ($56 million in hard costs and $14 million in soft costs) investment structure using both federal and Mississippi state[1] NMTC programs for the combined 30-room economy extended-stay hotel and 29-bed acute care rural hospital with integrated healthcare mall in Sharkey County, Mississippi. The project qualifies as it is located in a rural, non-metropolitan low-income community (LIC) census tract, with Sharkey County meeting federal NMTC eligibility criteria (poverty rate >20% and median family income <80% of statewide/metro median). The healthcare component (hospital and mall) aligns with NMTC use for health facilities in underserved areas,[2] while the hotel supports rural hospitality and tourism infrastructure,[3] such as job creation and economic revitalization in the Mississippi Delta. The NMTC allows taxpayers to receive a credit for investments in Community Development Entities that create jobs in low-income communities.[4] The NMTC allows investors to claim a tax credit totaling 39 percent of their investment in Community Development Entities (CDE) over 7 years.[5]

Total project costs are $70 million ($56 million hard costs + $14 million soft costs (e.g., fees, design, permits). The structure assumes a leveraged NMTC model (common for maximizing subsidy), where investor equity is combined with debt to form the Qualified Equity Investment (QEI). This flows through a Community Development Entity (CDE) to the project as Qualified Low-Income Community Investments (QLICIs), typically as two loans: a market-rate "A" loan and a below-market "B" loan (often interest-only and potentially forgivable after the 7-year compliance period for federal NMTC).[6] Federal and state NMTCs are twinned (layered in parallel structures) to enhance benefits, with the same or separate CDEs handling each. Assumptions include:

- Federal allocation: $40 million (realistic for a large rural project; CDEs often allocate $10 to $50 million per deal).
- Mississippi allocation: $16 million (matches the 2025 statewide annual cap; project could seek the full amount given its scale and impact).[7]
- Investor pricing: Federal credits at $0.85 per credit dollar (market rate for 2025 rural deals); state at $0.70 (lower due to shorter term and state-specific value).
- Fees: 5% of QEI (covering CDE, legal, and closing costs).
- Leverage source: A $40 million bridge/construction loan from a bank, grant, or project sponsor (e.g., via USDA Rural Development loans/grants for the hospital or conventional financing for the hotel), estimated at 6% interest.
- Net benefit: Estimated to be approximately 20-25% of total QEI as subsidy to the project (after fees), or approximately $13-$14 million total, reducing effective debt requirement.

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[1] Enacting Legislation https://www.novoco.com/public-media/documents/mississippi_code_57-105-1_072514.pdf-1 ; Amending Legislation SB 2598; S.B. 2373; H.B. 710; H.B. 499; H.B. 1901

[2] https://www.mossadams.com/articles/2023/03/health-care-new-markets-tax-credits-faq

[3] CBO Financial. https://cbofinancial.com/financing/cdfi/new-markets-tax-credit/tourism-and-hospitality-infrastructure/

[4] Internal Revenue Service publication New Market Tax Credits https://www.irs.gov/pub/irs-utl/atgnmtc.pdf

[5] General Accounting Office Report to Congressional Committees on New Market Tax Credits https://www.gao.gov/assets/gao-10-334.pdf

[6] U.S. Department of Treasury, CDFI Fund. https://www.cdfifund.gov/programs-training/programs/new-markets-tax-credit

[7] Novogradac March 2025: Mississippi Governor Signs Bill Extending Deadline, Increasing Cap for State NMTC. https://www.novoco.com/news/mississippi-governor-signs-bill-extending-deadline-increasing-cap-for-state-nmtc

Key Entities Involved

- **Project Sponsor/QALICB (Qualified Active Low-Income Community Business)**: A for-profit subsidiary or LLC owning/operating the project (e.g., "Sharkey-Issaquena Health & Hospitality LLC"). Must be located in the LIC and provide community benefits like healthcare access and jobs. Non-profit hospitals can use a for-profit affiliate.
- **CDE:** Certified entity (e.g., a national CDE like CBO Financial for hospitality or a health-focused one) with federal/state allocations. Manages QLICI and compliance. compliance (e.g., job creation tracking) is required for 7 years (federal) or 3 years (state).
- **Investment Fund:** Special-purpose entity (e.g., LLC) that pools investor equity and leverage debt to make the QEI into the CDE.
- **NMTC Investor:** Tax-motivated entity (e.g., bank or corporation) claiming credits. Can be the same for federal/state. Healthcare providers leasing medical retail space may be potential investors
- **Leverage Lender:** Provides debt (e.g., bank loan secured by project assets or grants).

Example Flow of Funds and Structure

FOR THIS PROJECT ADDITIONAL SOURCES OF FUNDING MAY BE LEVERAGED:

- ***CDBG-DR FUNDING***
- ***GOVERNOR REEVES MISSISSIPPI RURAL HEALTH TRANSFORMATION PROGRAM PLAN***
- ***EDA-DISASTER-2025 FY DISASTER SUPPLEMENTAL DEPARTMENT OF COMMERCE HTTPS://GRANTS.GOV/SEARCH-RESULTS-DETAIL/359225***

The twinned structure uses parallel federal and state paths, with shared leverage where possible. Total QEI: $56M ($40 million federal + $16 million state). Leverage is approximately $36.6 million (sourced once and split proportionally).

1. **Leverage Loan Origination:** The QALICB or sponsor secures a $36.6 million leverage loan or grant (e.g., from a community bank or USDA program for rural hospitals/hotels).
2. **Investment Fund Formation:** The fund receives:
    - NMTC Investor equity: approximately $19.4 million total ($13.26 million federal + $6.14 million state, based on pricing).
    - Leverage loan: $36.6 million.
3. **QEI to CDE:** Fund invests $56 million QEI into the CDE(s) ($40 million federal, $16 million state).
4. **QLICI to QALICB:** CDE lends approximately $53.2 million net (after 5% fees) to the QALICB as:

- Loan A (Senior, Market-Rate): approximately $36.6 million at 6% interest, amortizing over 20-30 years (mirrors leverage; repaid to lender).
- Loan B (Subordinate, Below-Market): approximately $19.4 million at 1% interest-only for 7 years (federal) or 3 years (state), potentially converted to equity or forgiven post-compliance.

5. **Project Financing Stack:** The $53.2 million QLICI covers approximately 76% of costs; remainder from equity ($5 million), grants ($7 million, e.g., HRSA for rural hospitals), or other debt ($4.8 million). NMTC proceeds fund construction, equipment (e.g., hospital beds, hotel kitchenettes), and soft costs.
6. **Exit:** After 7 years (federal) or 3 years (state), Loan B may be refinanced or forgiven, providing permanent subsidy (i.e., return $19.4 million to community to repay loans/bonds)

Component	Federal ($40 million QEI)	Mississippi ($16 million QEI)	Total
Total Tax Credits	$15.6 million (39%)	$3.84 million (24%)	$19.44 million
Investor Equity Contribution (at pricing)	$13.26 million ($0.85/credit)	$6.14 million ($0.70/credit, adjusted for shorter term)	$19.4 million
Leverage Loan	$26.74 million	$9.86 million	$36.6 million
Fees (5%)	$2 million	$0.8 million	$2.8 million
Net Proceeds to Project (Subsidy)	approximately $11.26 million (28% of QEI)	approximately $5.34 million (33% of QEI)	approximately $16.6 million
Claim Schedule	Years 1-3: $2 million/yr; Years 4-7: $2.4 million/yr	Years 1-3: $1.28 million/yr	n/a

Net Benefit: $16.6 million subsidy reduces the effective project cost to $53.4 million; enhancing the affordability and feasibility of the project in a high-poverty area. Additional benefits include the creation of 100 to 150 jobs for hospital staff, hotel operations and in-community job healthcare and hospitality training opportunities.

Projected Revenue from Medical Retail Space Leasing

Image 1: Magee, MS Medical Office

In Mississippi, the average cost to lease medical office space ranges from approximately $12.00 to over $30.00 per square foot per year.[8] Rates vary based upon location, property class, and amenities. Examples include:

- **Magee Medical Office Building.**[9] Currently advertising $6,130 per month for a 4,904 sq. ft. space (this is $15 per square foot per year). This full-service medical office building in Magee, MS, offers a variety of space configurations suitable for traditional clinics and general offices. The first-floor vacancy includes a former pharmacy with a drive-through. Traditional medical clinic and medical-related general office spaces are available on the second and third floors. The property offers full-service leases, which include daily janitorial services and utilities.
- **In Southaven,** a medical space was listed at $28.64 per square foot per year.[10]

[8] There was a listing found in Starkville Mississippi for $37 per square foot per year. https://www.loopnet.com/search/commercial-real-estate/starkville-ms/for-lease/?view=map&e=u
[9] https://realmo.com/listing-m/360-simpson-highway-149-magee-ms-39111/1236393288815914408
[10] https://realmo.com/medical-offices/for-lease/ms/

- **In Biloxi,** a medical office space was listed at $20.00 per square foot per year.[11]

Considerations

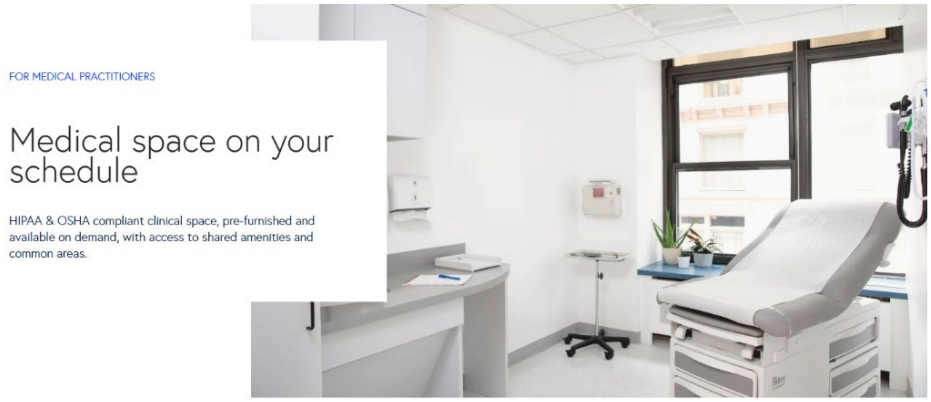
Sharkey and Issaquena Counties are rural areas with extreme poverty rates and unmet healthcare needs. For many healthcare practitioners the market does not support a full-time presence, but there is sufficiency in the market to provide services on a schedule of one- or two-days per week. To bridge this gap requires a comprehensive health care solution the meets the challenges faced by healthcare professionals who seek to provide services to the rural population. The healthcare medical mall offers a workspace designed to accommodate various specialties under one roof. Private, customizable, and turnkey office suites provide a flexible solution that enable practitioners to cost effectively provide multidisciplinary patient care that would not be otherwise available in rural Sharkey and Issaquena Counties.

Eliminating Barriers to Market Entry for Health Care Practitioners, Reducing Overhead, Enhancing Support

Opening a brick-and-mortar office can be a significant challenge due to regulations and other factors. The rising cost of establishing and maintaining a private medical practice is a major obstacle for many healthcare providers. "According to Doctorly, consultants estimate that the cost to launch a small primary care practice ranges from $70,000 to more than $100,000." “Flexible, affordable medical office space reduces the barriers to market entry in a rural area. It also provides a viable and cost-effective alternative that benefits healthcare providers while allowing them to launch, expand, and grow their medical practice in response to market demand.”[12]

Additional Considerations: Medical Office Timesharing allows the use of a particular medical space on specific dates or times – to be shared by multiple healthcare providers

Image 2: Timeshare Medical Office Space Sourced from Lina http://lina.co/on-demand/medical



[11] Ibid.
[12] South Florida Hospital News Healthcare Report (2023). Empowering Independent Healthcare Practitioners in Private Practice. https://southfloridahospitalnews.com/empowering-independent-healthcare-practitioners-in-private-practice/.

Assumptions for a 10-Year Pro Forma for the Medical Mall Complex (Practitioner Storefronts Only)

Available Space: 25,000 square feet

Base Rent: $12 per square foot per year, with a 3% annual escalation to account for typical lease increases.

Occupancy/Vacancy: 5% vacancy rate (common for stabilized properties like medical malls).

Operating Expenses: Starting at $5 per square foot per year (covering maintenance, utilities, insurance, property taxes, etc.), with a 2% annual escalation.

No Debt or Capital Expenditures: This is a simplified operating pro forma focusing on Net Operating Income (NOI). It does not include financing, depreciation, or major capital improvements.

Potential Gross Income (PGI): Total possible rental income at full occupancy.

Effective Gross Income (EGI): PGI minus vacancy allowance.

NOI: EGI minus operating expenses.

Table 3: 10-Year Pro Forma for Medical Mall Storefront Only

Year	Rent Per Square Ft.	Potential Gross Income	Cost of Vacancy @ 5%	Effective Gross Income (EGI)	Expense Per Sq. Ft.	Total Expenses	Net Operating Income
1	$12.00	$300,000	$15,000	$285,000	$5.00	$125,000	$160,000
2	$12.36	$309,000	$15,450	$293,550	$5.10	$127,500	$166,050
3	$12.73	$318,270	$15,914	$302,357	$5.20	$130,050	$172,307
4	$13.11	$327,818	$16,391	$311,427	$5.31	$132,651	$178,776
5	$13.51	$337,653	$16,883	$320,770	$5.41	$135,304	$185,466
6	$13.91	$347,782	$17,389	$330,393	$5.52	$138,010	$192,383
7	$14.33	$358,216	$17,911	$340,305	$5.63	$140,770	$199,535
8	$14.76	$368,962	$18,448	$350,514	$5.74	$143,586	$206,928
9	$15.20	$380,031	$19,002	$361,029	$5.86	$146,457	$214,572
10	$15.66	$391,432	$19,572	$371,860	$5.98	$149,387	$222,474

Table 4: Funding Sources for Rural Hospitals

Source	Description	Eligibility/Notes	Funding Type/Amount
Small Rural Hospital Improvement (SHIP) Grant	Supports small rural hospitals with initiatives like quality improvement, health IT adoption, and staff training. Administered by Mississippi State Department of Health (MSDH).	Hospitals with ≤49 beds in rural areas (all Critical Access Hospitals qualify). Annual application required; contact MSDH at 601-576-7874.	Grants; amounts vary by state allocation (MS received part of $43 million national in FY2024).
Rural Health Transformation Program (RHTP)	$50B federal fund over 5 years (FY2026–2030) for rural health improvements, including hospital sustainability, uncompensated care, and infrastructure. MS expects approximately $500 million; state plan due by Dec 31, 2025.	State-level application; funds flow to eligible rural providers like 29-bed acute care hospitals for operations and transformation. Public input ongoing via MS Division of Medicaid survey (closed Aug 2025).	Grants; up to $10B/year nationally, with MS allocation TBD.
Delta Health Systems Implementation Program (HRSA)	Focuses on financial/operational improvements, quality care, telehealth, and workforce development for Delta hospitals.	Rural hospitals in 252 Delta counties/parishes, including Sharkey County.	Grants; multi-year awards, e.g., $10 million over 5 years for similar Delta support in recent cycles.
Delta Region Community Health Systems Development (DRCHSD) Program (HRSA/DRA)	Provides free technical assistance for health system enhancements, including hospital operations and community partnerships.	Critical Access Hospitals and rural facilities in MS Delta region.	Technical assistance (non-monetary); extends to implementation grants.
Delta Health Care Services Grant (USDA Rural Development)	Addresses unmet health needs through equipment, facilities, or services in the Delta.	Public entities/non-profits serving Delta residents; hospitals eligible.	Grants up to $100K; annual cycle.
FCC Rural Health Care Program	Discounts on telecommunications and broadband for telehealth and connectivity.	Eligible health care providers, including rural hospitals.	Discounts up to 85% on services; ongoing.
Rural Hospital Flexibility (Flex) Program (HRSA)	Helps designate/operate as Critical Access Hospital (CAH) for enhanced Medicare payments; includes grants for quality improvement.	Small rural hospitals pursuing/converting to CAH status (≤25 beds). MS has 68 CAHs; Sharkey-Issaquena Community Hospital may qualify or expand.	Grants ~$100K–$200K per hospital; technical assistance included.
State Funding Sources - Mississippi prioritizes rural hospitals through MSDH and Medicaid Division:			
Source	**Description**	**Eligibility/Notes**	**Funding Type/Amount**
Mississippi Rural Hospital Loan Program (MSDH)	Low-interest loans for facility upgrades, staffing, or new services.	Licensed rural hospitals with ≤50 acute beds in good financial standing; ongoing applications. Contact: 601-576-7216 or RHLP@msdh.ms.gov.	Loans $25K–$100K at 1% fixed interest; 5–20-year terms; $1K app fee.
Rural Health Transformation Fund (State Proposal)	State-level fund from RHTP allocation for uncompensated care, capital projects, and equipment.	Rural hospitals; tied to federal RHTP approval.	Potential $500 million over 5 years for MS rural providers; planning phase in 2025.
Other Potential Sources			
• Medicare/Medicaid Reimbursements: Enhanced CAH payments (cost-based) and state-directed payments for rural hospitals; apply via CMS.			
• Private Foundations: Delta Health Alliance (focuses on MS Delta hospitals for grants approximately $50K–$500K); Robert Wood Johnson Foundation (rural health equity grants).			
• Loans/Bonds: USDA Community Facilities Loans/Grants (up to 75% grant for essential facilities); hospital revenue bonds via MS Health Facilities Authority.			

See source documentation and links on following page.

References for Hospital Funding

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    - MSDH SHIP Page: https://msdh.ms.gov/page/44,3969,111,304.html
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    - National Rural Health Resource Center SHIP TA: ship-ta@ruralcenter.org for tools/webinars.
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- Mississippi State Office of Rural Health. CAH Directory (68 facilities, 2025).
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- MSDH Rural Health Loan Program. Email: RHLP@msdh.ms.gov
- Mississippi Division of Medicaid. RHTP State Plan Draft (Oct 2025).
- CMS Guidance on State-Directed RHTP Funds (Sep 2025).
- CMS. Critical Access Hospital Payment System. https://www.cms.gov/CAH
- Delta Health Alliance. Grant Opportunities for Delta Hospitals (2025).
- Robert Wood Johnson Foundation. Systems for Action: Rural Health.
- USDA RD. Community Facilities Direct Loan & Grant Program.
- Mississippi Development Authority. Health Facilities Revenue Bonds.
- FEMA. Public Assistance: Rolling Fork Tornado (DR-4697-MS).

In Sharkey County, there were 14 fatalities and 150 injuries associated with the March 24, 2023, EF-4 tornado.[13] During this event, more than $83 million in property damage and $136,000 in crop damage was initially reported by FEMA, this included significant damage to the Rolling Fork Elementary School and South Delta High School.

The Sharkey-Issaquena Community Hospital

Photo 1: Sharkey-Issaquena Hospital Field Tents at the National Guard Armory

Photo 2: Sharkey-Issaquena Hospital Temporary Patient Care Units at Rolling Fork National Guard Armory

On March 24, 2023, an EF-4 tornado ripped off the roof and destroyed the integrity of the building envelope of the Sharkey-Issaquena Community Hospital; damage to the building and equipment crippled the hospital and forced the closure of the facility. The Sharkey-Issaquena Community Hospital (License #51-005) is a not-for-profit Critical Access rural hospital, jointly owned by Sharkey and Issaquena Counties that meets the healthcare needs of residents living in the Delta counties of Sharkey, Issaquena, and the peripheral. Upon having to abandon the hospital facility at 47 South Fourth Street in Rolling Fork, Mississippi, hospital personnel set up an emergency tent field hospital at the Rolling Fork National Guard Armory to respond to the needs of residents injured by the tornado. The hospital subsequently moved to a multi-purpose building at the intersection of Highway 61 and West Avenue, where it currently operates. The hospital was determined by FEMA to be damaged beyond repair, requiring a new facility.

The Sharkey-Issaquena Community Hospital is a rural hospital serving residents in the Mississippi Delta, the nearest alternate hospitals are in Vicksburg, Yazoo City, and Greenville—all of these hospitals are a minimum of a 45-minute drive from the location of the Sharkey-Issaquena Community Hospital (see Map 1 on page 28). Prior to being damaged, the hospital employed 119 people with salaries, wages, and employee benefits of approximately $7,022,133 annually.[14]

The Sharkey-Issaquena Community Hospital campus consisted of a 29-bed hospital with 19 medical and 10 geriatric psychiatric beds; services included:[15]

• 24-hour Emergency Room	• Rehabilitation Clinic - Physical, Occupational & Speech Therapy
• Ambulance Service	• Wellness & Fitness Center
• 24-hour Clinical Laboratory, CT-Scans, and Trauma Services	• Senior Living - Intensive Outpatient Program
• Mobile MRI	• Wound Care Clinic
• Sonograms	• Pediatric Services
• Medical Unit	• Acute Respiratory Care
• Observation Unit	• Family Medical Clinic
• Level IV Trauma Center	• Geriatric Psychiatric Services
• Outpatient Service Provided	• Memories - Dementia Unit

[13] National Oceanic and Atmospheric Administration (NOAA) National Centers for Environmental Information Storm Event Database. *"Mississippi Event Report: EF4 Tornado (Sharkey County)".*

[14] American Hospital Association 2023 Annual Survey of Hospitals in the United States https://www.aha.org/statistics/fast-facts-us-hospitals. Accessed February 1, 2025.

[15] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services: Provider of Services File – Hospital & Non-Hospital Facilities. https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities

Hospital Project Justification

The Sharkey-Issaquena Community Hospital is the healthcare hub for the Lower Mississippi Delta region; it serves some of the poorest counties in the state of Mississippi. The need for a hospital to provide medical and health care services in the Mississippi Delta counties served by the Sharkey-Issaquena Community Hospital is significant. Prior to its' destruction by an EF-4 tornado, the hospital predominantly served the residents of Sharkey, Issaquena counties, and residents living in some areas of Washington County, and Yazoo County (see Map 1 page 28). The United Health Foundation's *2024 County Health Rankings Report* ranked Mississippi as 49 out of the 50 states in the United States (Table 5 below). According to the Mississippi Department of Health's *County Health Rankings: "Sharkey County is faring worse than the average county in Mississippi for Health Outcomes, and worse than the average county in the nation."*[16]

Table 5: Health Rankings for the State of Mississippi and Relevant Counties 2024

Comparative Health Rankings	Mississippi Rank	United States	Mississippi	Issaquena County	Sharkey County
Social & Economic Factors	**47**				
Injury Deaths per 100,000 people (homicides, suicides, motor vehicle creashes, poisonings, etc.)	**43**	80	100.0	No Data	143
Food Insecurity (% of households)	**47**	10.0%	20.0%	23.0%	18.0%
Income Inequality (80-20 Ratio) - ratio of household income at the 80th percentile to income at the 20th percentile i.e., in Sharkey County households with higher incomes had income 6.3 times higher than that of households with lower incomes.	**47**	4.9	5.3	5.6	6.3
% Children in Poverty	**32**	16.0%	26.0%	89.0%	54.0%
High School Completion (% of adults age 25+)	**45**	89.0%	86.0%	64.0%	80.0%
% of Children in Single-Parent Household		25.0%	36.0%	38.0%	53.0%
Median Household Income	**50**	$74,800	$52,800	$36,900	$36,400
High-Speed Internet (% of households)	**50**	88.0%	80.0%	36.0%	58.0%
Voter Participation (% of U.S.) citizens age 18+)	**28**	67.9%	58.7%	64.1%	64.9%
Physical Environment	**36**				
Presence of Drinking Water Violations	**20**		**N/A**	**Yes**	**Yes**
% Homeowners		65.0%	69.0%	51.0%	58.0%
Drive Alone to Work (% of workers age 16+)*	**50**	72.0%	84.0%	77.0%	78.0%
Long Commute - Driving Alone	**50**	36.0%	34.0%	30.0%	37.0%
Severe Housing Problems (% of occupied housing units)	**28**	17.0%	14.0%	14.0%	11.0%
Clinical Care	**47**				
Dentists Ratio	**46**	1,360:1	1,939:1	1,273:0	3,488:0
Mental Health Provider Ratio	**41**	320:1	463:1	N/A	3,490:1
Primary Care Physicians Ratio	**35**	1,330:1	1,875:1	1,280:0	3,663:1
% Uninsured Adults	**43**	12.0%	18.0%	21.0%	21.0%
% Uninsured Children	**43**	5.0%	7.0%	11.0%	9.0%
% of Medicare enrollees who received annual flu vaccines	**44**	46.0%	40.0%	32.0%	35.0%
Mammography Screening	**33**	43.0%	40.0%	58.0%	35.0%
Preventable Hospitalizations (Discharges per 100,000 Medicare beneficiaries age 18+)	**47**	2,681	3,423	No Data	3,275
Health Behaviors	**50**				
Access to Exercise Opportunities (Percent of people who live close to a park or recreational facility)	**46**	84.0%	58.0%	8.0%	1.0%
Physical Inactivity (% of adults)	**48**	23.0%	30.0%	40.0%	38.0%
Food Environment Index Scale of 0 (worst) to 10 (best) includes access to healthy food and food insecurity	**48**	7.7	4.0	4.4	6.5
Obesity (% of adults)	**47**	34.0%	39.0%	45.0%	48.0%
Sexually Transmitted Infections (Cases per 100,000 population)	**49**	495.5	750.0	No Data	1,283.10
HIV Prevalence Rate	**42**	382	400	No Data	No Data
Teen Births (Births per 1,000 females ages 15-19)	**50**	17.0	29.0	No Data	67.0
Insufficient Sleep (% of adults)	**38**	33.0%	35.0%	40.0%	39.0%
Smoking (% of adults)	**44**	15.0%	20.0%	28.0%	24.0%
Excessive Drinking (% of adults)	**8**	18.0%	16.0%	13.0%	11.0%
Alcohol-Impared Driving Deaths		26.0%	19.0%	33.0%	25.0%
Health Outcomes	**46**				
Life Expectancy in Years	**50**	77.6	73.7	No Data	68.5
Premature Death (Years lost before age 75 per 100,000 population)	**49**	8,000	12,697	No Data	18,985
Drug Overdose Deaths (Drug Poisoning Deaths per 100,000)	**15**	27.0	20.0	No Data	No Data
Motor Vehicle Mortality Rate (Motor Vehicle Crash Deaths per 100,000 population)	**50**	12	25	No Data	40
Frequent Physical Distress (% of adults)	**40**	10.0%	12.0%	16.0%	15.0%
Poor Physical Health Days per Month		3.3	3.7	4.7	4.5
Frequent Mental Distress (% of adults)	**22**	15.0%	15.0%	18.0%	18.0%
Poor Mental Health Days per Month		4.8	4.7	5.1	5.2
Diabetes Prevalence	**50**	10.0%	14.0%	16.0%	17.0%
% of Adults Reporting Fair or Poor Health		14.0%	21.0%	31.0%	29.0%
Average Number of Physically Unhealthy Days per Month		3.3	3.7	4.7	4.6
Low Birth Weight (% of live births)	**50**	8.0%	12.0%	19.0%	14.0%
Overall	**49**				

Source: America's Health Rankings.org and Mississippi Department of Health 2024 County Health Report Card
County Health Rankings is a program of the University of Wisconsin Population Health Institute.

[16] Mississippi State Department of Health County Report Card https://msdh.ms.gov/page/19,0,209.html. Accessed February 2, 2025.

The Benefit of Hospitals to Low-Income Areas.

Hospitals are among the largest employers in the United States, serving as economic anchors in their communities. There is a deep need for health care services within the HUD-Identified MID Sharkey County—Rolling Fork ZIP code 39159—and multiple other geographic areas impacted by Presidentially declared disaster FEMA-4697-DR. Losing the hospital will leave the Lower Mississippi Delta area without vital health services, exacerbating the existing health and economic challenges. Hospitals in poverty areas are essential for providing access to health care, particularly for populations with limited financial resources.[17] Hospitals act as safety nets, providing emergency care, maternal health programs, and treatment for chronic conditions – these services are vital for populations with limited incomes, limited insurance, and the inability to pay. For example, the Sharkey-Issaquena Community Hospital's Financial Assistance Program (FAP) provides financial assistance, based on need, to patients who lack the ability to pay for emergency and other non-elective medically necessary care.[18]

The role of hospitals in reducing health disparities is well-documented. For example, the American Academy of Family Physicians notes that poverty is associated with adverse health outcomes, to include shorter life expectancy, higher infant mortality rates, and increased death rates for all leading causes.[19, 20] Health Care Rankings for the State of Mississippi, Sharkey County, and Issaquena County further document the justification for rebuilding the Sharkey-Issaquena Community Hospital to address the adverse health outcomes experienced by residents that will be served by the Hospital (Table 5 on page 26). For example, the relatively high incidence of injury deaths (143/100,000 in Sharkey County as compared to 80/100,000 in the United States) from motor vehicle accidents, suicides, and poisonings; high percentage of uninsured adults (21% in Sharkey County as compared to 12% in the United States; high obesity rates (48% in Sharkey County versus 34% in the United States) are but a few examples of the deep need for access to health care for the residents of Rolling Fork, Sharkey County, and the surrounding Lower Delta Region of Mississippi.

Economically, hospitals make a significant contribution to low-income areas. Hospitals create jobs for workers across a broad range of educational attainment and income levels; importantly, they create entry-level job opportunities for workers to gain experience that enables them to advance up the income ladder. For example, the Sharkey-Issaquena Community Hospital partners with the Delta Health System to provide work experience to high-school students in a medical setting as patient care coordinators, creating a pathway for students to transition into healthcare employment. Hospitals jobs are filled by local residents in low-income communities. Hospitals provide job training programs for nursing students and healthcare professionals and provide employment opportunities that support community stability and reduce poverty. By keeping people healthy, hospitals also improve the productivity of workers and support a high quality of life. In rural areas, the presence of a hospital provides access to health care and provides financial protection against high medical costs; this helps to prevent families from falling into poverty due to high healthcare expenses.

The importance of the health care sector to the local economy has been well documented [21, 22, 23] as the cornerstone of the health care sector; hospitals are widely recognized as anchor institutions.[24] Health care and, particularly, the hospital, are critically important to business and industry and to the retired community, as well as to the health care of all community residents. The Sharkey-Issaquena Community Hospital is a vital anchor in the economy of Sharkey and Issaquena counties and the surrounding area; it creates jobs, supports spending in the local economy, and provides essential health care. The economic impact of The Sharkey-Issaquena Community Hospital extends beyond direct financial contributions; it also produces induced and indirect effects that stimulate additional local income, employment,

[17] Lee, R. (2024). How Poverty and Location Limit Access to Health Care. https://rendia.com/resources/insights/poverty-location-limit-access-health-care/
[18] Sharkey-Issaquena Community Hospital Financial Assistance Program. https://www.simedical.org/patients-and-visitors/financial-services/
[19] Position Paper: Poverty and Health – The Family Medicine Perspective. https://www.aafp.org/about/policies/all/poverty-health.html
[20] Dave, G., Wolfe, M. K., & Corbie-Smith, G. (2021). Role of hospitals in addressing social determinants of health: A groundwater approach. Preventive medicine reports, 21, 101315.
[21] Eilrich, F.C., Doeksen, G.A. and St. Clair, C.F. "The Economic Impact of Recent Hospital Closures on Rural Communities." National Center for Rural Health Works. [www.ruralhealthworks.org (August 2015)]
[22] House, P. "Community Benefits of Critical Access Hospitals in Washington." University of Washington, School of Medicine report. August 2007.
[23] Chirilos, T.N. and Nostel, G. "Further Evidence on the Economic Effects of Poor Health." Review of Economic and Statistics. Volume 67(1): 61-69. 1985.
[24] Harker, P. T., and Diamond, D. (2022). Anchor Impact: Understanding the Role of Higher Education and Hospitals in Regional Economies. Federal Reserve Bank. https://www.philadelphiafed.org/-/media/FRBP/Assets/Community-Development/Reports/anchor-economy-report-92022.pdf

Map 1: 15-Minute, 30-Minute, and 45-Minute Drive Time from Sharkey-Issaquena Hospital Site

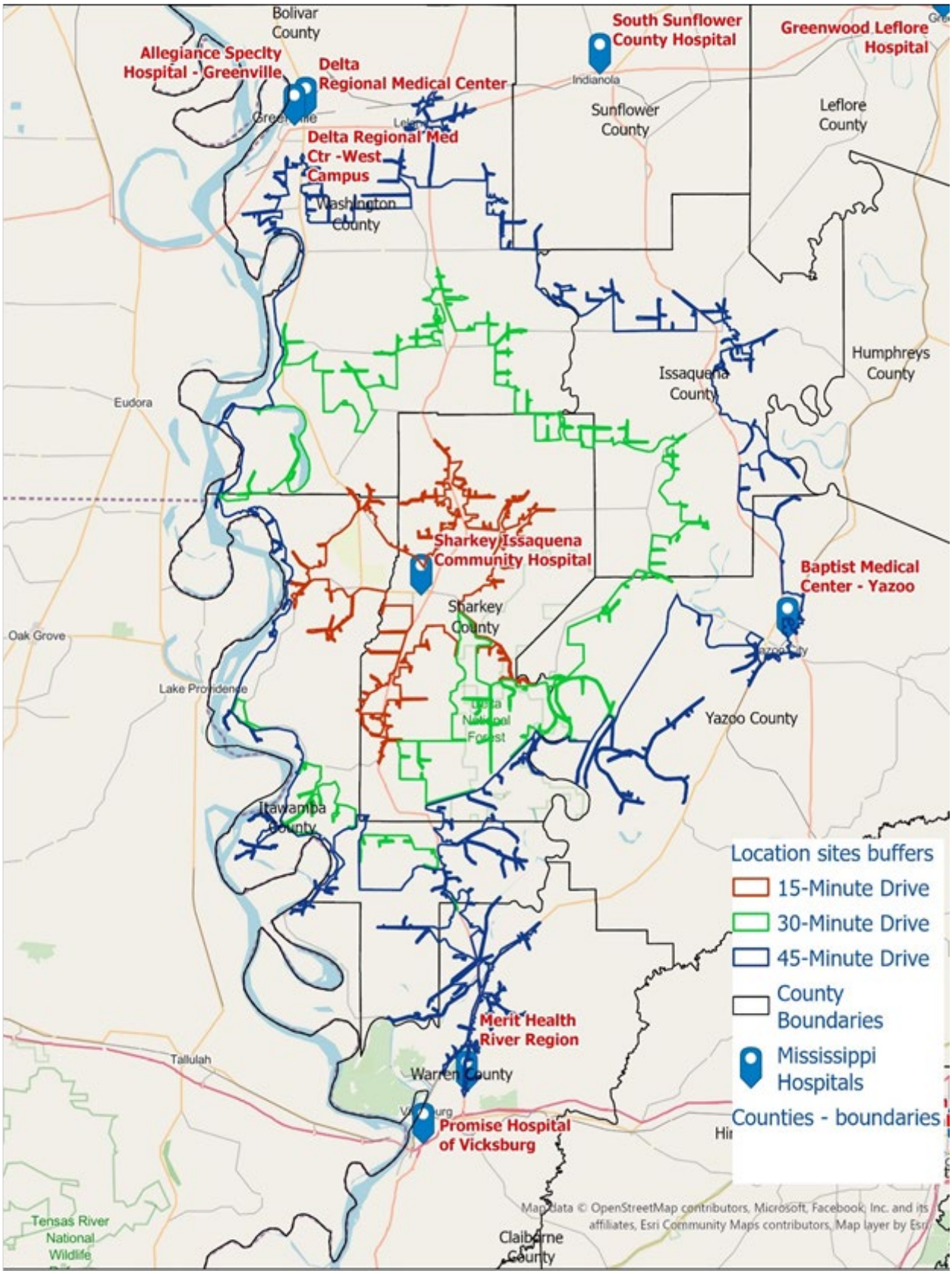


Table 6: 2024 Health Care and Insurance Expenditures within 15- , 30- , and 45-Minute Drive Time from proposed Building Site of Sharkey-Issaquena Memorial Hospital

Health Care Expenditure Items	Spending Potential Index	Average Spending	Total Spending	Spending Potential Index	Average Spending	Total Spending	Spending Potential Index	Average Spending	Total Spending
	15-Minute Drive Time			30-Minute Drive Time			45-Minute Drive Time		
Medical Care	64	$1,733.24	$2,135,351	59	$1,581.33	$4,959,048	55	$1,490.63	$15,262,573
Physician Services	60	$197.49	$243,302	55	$180.90	$567,296	52	$172.52	$1,766,446
Dental Services	54	$272.11	$335,238	50	$248.24	$778,493	48	$239.96	$2,456,986
Eyecare Services	61	$57.67	$71,045	57	$53.54	$167,908	55	$51.31	$525,361
Lab Tests, X-rays	60	$52.56	$64,748	54	$47.44	$148,763	53	$45.97	$470,637
Hospital Room and Hospital Services	58	$163.23	$201,096	52	$145.67	$456,834	51	$142.65	$1,460,593
Convalescent or Nursing Home Care	80	$35.35	$43,553	73	$32.34	$101,404	61	$27.13	$277,735
Other Medical Services (1)	53	$109.40	$134,785	48	$98.99	$310,421	47	$97.69	$1,000,236
Nonprescription Drugs	70	$124.78	$153,734	65	$115.04	$360,751	60	$106.22	$1,087,553
Prescription Drugs	77	$318.65	$392,582	71	$294.56	$923,729	68	$279.58	$2,862,651
Nonprescription Vitamins	74	$119.11	$146,742	67	$107.97	$338,605	56	$90.46	$926,191
Medicare Prescription Drug Premium	84	$110.35	$135,951	77	$101.12	$317,127	69	$91.48	$936,698
Eyeglasses and Contact Lenses	62	$78.55	$96,778	56	$71.25	$223,425	53	$66.80	$683,961
Hearing Aids	80	$28.30	$34,868	69	$24.43	$76,614	62	$21.81	$223,321
Medical Equipment for General Use	61	$6.08	$7,493	54	$5.42	$16,995	54	$5.35	$54,776
Other Medical Supplies/Equipment (2)	64	$59.61	$73,437	59	$54.43	$170,683	56	$51.71	$529,426
Total Health Care	**66**	**$5,070.67**	**$6,247,060**	**60**	**$4,642.13**	**$14,557,718**	**57**	**$4,370.78**	**$44,752,405**

Health Insurance Expenditure Items	Spending Potential Index	Average Spending	Total Spending	Spending Potential Index	Average Spending	Total Spending	Spending Potential Index	Average Spending	Total Spending
	15-Minute Drive Time			30-Minute Drive Time			45-Minute Drive Time		
Blue Cross/Blue Shield	65	$881.82	$1,086,397	61	$818.15	$2,565,726	58	$789.62	$8,084,927
Fee for Service Health Plan	55	$547.15	$674,086	51	$506.66	$1,588,881	50	$497.08	$5,089,633
HMO	52	$393.73	$485,076	47	$358.30	$1,123,623	45	$342.84	$3,510,364
Medicare Payments	86	$976.31	$1,202,816	78	$887.51	$2,783,247	70	$795.07	$8,140,748
Long Term Care Insurance	70	$47.45	$58,461	64	$43.21	$135,522	60	$40.51	$414,820
Dental Care Insurance	54	$97.67	$120,330	50	$90.75	$284,593	50	$90.21	$923,698
Vision Care Insurance	59	$26.16	$32,227	55	$24.35	$76,352	55	$24.32	$249,005
Prescription Drug Insurance	82	$6.25	$7,694	76	$5.76	$18,070	73	$5.54	$56,738
Other Single Service Insurance (3)	60	$9.23	$11,373	53	$8.19	$25,695	49	$7.64	$78,266
Medicaid Premiums	64	$7.25	$8,928	59	$6.66	$20,877	58	$6.53	$66,890
Tricare/Military Premiums	71	$8.30	$10,224	67	$7.80	$24,447	62	$7.22	$73,895
Children's Health Ins Program Premiums	50	$0.51	$632	45	$0.46	$1,434	48	$0.49	$5,007
Total Health Insurance	67	$3,337.43	$4,111,709	61	$3,060.80	$9,598,670	58	$2,880.15	$29,489,833

Data Note: The Spending Potential Index (SPI) is household-based, and represents the amount spent for a product or service relative to a national average of 100. Detail may not sum to totals due to rounding.

(1) Other Medical Services includes Services by Medical Professionals other than Physicians, Outpatient Hospital Care, Blood Donation, and Ambulance, Dialysis, Emergency Room, Oxygen or Rescue Services.

(2) Other Medical Supplies/Equipment includes Topicals, Dressings, Supportive and Convalescent Medical Equipment, Rental of Medical Equipment for General Use, and Rental of Supportive and Convalescent Medical Equipment.

(3) Other Single Service Insurance Other Single Service Insurance includes health insurance coverage that provides for only one type of service, other than dental care, vision care, prescriptions, and long-term care.

Source: Esri forecasts for 2024 and 2029; Consumer Spending data are derived from the 2021 and 2022 Consumer Expenditure Surveys, Bureau of Labor Statistics.

and tax revenues to support public services. The presence of a hospital in a community encourages capital investment and new business formation due to the association between the health care industry and an educated workforce. The design of the proposed hospital with 25,000 square feet of medical mall storefront office for lease to healthcare providers will act as a significant magnet to attract new business formation of the offices of health care providers i.e., physicians, dentists, pharmacies, or laboratories. The presence of the hospital will attract other businesses and industry to locate within the community. Due to increasing demand for health care services, hospitals represent significant opportunities for residents in low-income communities to secure high-paying jobs in the growing health care sector.

Economic Impact. The Sharkey-Issaquena Community Hospital plays a vital role in the economic stability and growth of surrounding communities through direct, induced, and indirect impacts. The impact from the ongoing operations of a hospital occurs every year the hospital is in operation. Direct impacts stem from the hospital's operational spending on employment. The induced effects arise from the spending by hospital employees in the local economy. Indirect impacts are generated through the supply chain by the goods and services that are purchased by the hospital. Research findings from the National Center for Rural Health Works indicate that ten to 15 percent of the jobs in a rural community are in health care and rural hospitals are one of the top employers in the rural community.[25]

To generate an estimate of the economic impact of the Sharkey-Issaquena Community Hospital on the local economy, the Stennis Institute examined employment and revenue data from the operating activities of the Hospital during 2020.[26] At that time the hospital employed 120 people and had a payroll of approximately $7.5 million. Because it may not be valid to extrapolate these estimates to the current health care operating environment, the Stennis Research Team used assumptions related to Huff's Spatial Interaction Model to create an econometric input-output model using IMPLAN© software. The context of Huff's Model is the premise that the flow of patients between different hospitals is based on the principle that larger hospitals offering more services will attract more patients from nearby areas.

As the distance between a patient and a hospital increases, the "gravity" between them decreases.[27] This model assumes that patients will be more likely to choose a hospital that is closer to them (Sharkey-Issaquena Community Hospital), moderated by perception of quality of care, hospital capacity, and the range of specialists available. Many factors cannot be fully measured by spatial interaction models, including a patient's income, insurance coverage, and ability to travel for care.[28] With greater distance between the patient and the hospital, the hospital's share of health care expenditures a hospital attracts from an area is inversely proportional to distance and directly proportional to the range of health care services provided by the hospital – this is measured by a distance decay coefficient.

Examining the health care market within 15-minute, 30-minute, and 45-minute drive times (Map 1 on page 28) from the proposed hospital construction site, the Stennis Institute estimated that the Sharkey-Issaquena Community Hospital has the potential to capture a large share of the hospital spending within the 30-minute drive time radius (Table 6 on page 29). Based upon this assumption, the Stennis Team used econometric input-output modeling to evaluate the economic impact of the Sharkey-Issaquena Community Hospital. As shown in Table 7 below, it is estimated that 76 full-time equivalent employees will work at the Sharkey-Issaquena Community Hospital; labor income associated with these direct jobs is estimated to be approximately $6.2 million. An additional 66 full-time equivalent, indirect and induced jobs will be supported throughout the region by the ongoing operations of the hospital, and the total economic output of the hospital is projected to be $24.7 million annually.

Table 7: Projected Economic Impact of Sharkey-Issaquena Community Hospital

Impact	Employment	Labor Income	Value Added	Output
1 - Direct	75.78	$6,190,011.10	$7,522,753.95	$14,557,718.00
2 - Indirect	36.52	$1,590,281.47	$2,567,543.70	$5,317,006.28
3 - Induced	29.54	$1,302,963.20	$2,764,651.14	$4,811,294.33
Total	141.84	$9,083,255.77	$12,854,948.78	$24,686,018.61

Source: IMPLAN© inputs by Stennis Institute of Government & Community Development

[25] Gerald A. Doeksen, Cheryl F. St. Clair, and Fred C. Eilrich, (2016) Economic Impact of a Critical Access Hospital on a Rural Community.
[26] Source: The Sharkey-Issaquena Community Hospital Independent Auditor's Reports and Financial Statement September 30, 2021, and 2020 conducted by BKD CPAs and Advisors from Jackson, Mississippi. https://www.google.com/search?client=firefox-b-1-d&q=Sharkey-Issaquena+County+Audit+2023
[27] Khan, A. A. (1992). An integrated approach to measuring potential spatial access to health care services. Socio-economic planning sciences, 26(4), 275-287.
[28] McLafferty, S. (2020). Place and quantitative methods: critical directions in quantitative approaches to health and place. Health and Place, 61, 102232.

The annual fiscal impacts associated with the ongoing operations of the Sharkey-Issaquena Community Hospital are estimated to be approximately $850,000; of this amount, combined TOPI and personal property tax revenues to county governments are estimated at $235,842 and sales tax revenues are estimated at $382,303 annually (*Table 8* below):

Table 8: Annual Fiscal Impacts Associated with the Ongoing Operations of the Hospital

Transfer Code	Description	Sub County (Special Districts)	County General	County Tax Impact	State Tax Impact	Total
15020	TOPI: Sales Tax	$7	$5,679	$1,760	$374,857	$382,303
15021	TOPI: Property Tax	$106,653	$36,473	$82,767	$1,824	$227,717
15022	TOPI: Motor Vehicle License	$0	$0	$0	$4,308	$4,308
15023	TOPI: Severance Tax	$0	$0	$0	$2,586	$2,586
15024	TOPI: Other Taxes	$1,239	$1,454	$3,601	$11,891	$18,185
15025	TOPI: Special Assessments	$580	$71	$1	$0	$652
15026	OPI: Corporate Profits Tax	$0	$0	$0	$49,582	$49,582
15027	Personal Tax: Income Tax	$0	$0	$0	$150,034	$150,034
15030	Personal Tax: Motor Vehicle License	$0	$0	$0	$6,070	$6,070
15031	Personal Tax: Property Taxes	$3,821	$1,306	$2,933	$65	$8,125
15032	Personal Tax: Other Tax (Fish/Hunt)	$0	$0	$0	$1,146	$1,146
Total		**$112,299**	**$44,984**	**$91,061**	**$602,986**	**$851,329**

Source: IMPLAN© model assumption and inputs by Stennis Institute Research Teram

Authors' note: Realized tax revenues may be overstated due to potential property tax abatements that may be allocated by county or municipal governments and the non-profit status of the hospital may reduce sales tax revenues.

Community investments that utilize HUD CDBG or other federal funds, i.e., New Market Tax Credits, must demonstrate that job opportunities will benefit residents of the surrounding low-income communities within which these investments are made. Consideration must be given to whether the jobs created will align with the educational attainment level of residents of the community and the other consider is whether the jobs will pay a "*living wage*." As shown in Table 9 at right, approximately 30 percent of the jobs created require a High School diploma or less and 63.3 percent of all jobs require an associate's degree or less. This demonstrates that the investment to rebuild the Sharkey-Issaquena Community Hospital will create employment opportunities that are well-aligned with the education attainment levels of residents in the surrounding low-income communities and that entry-level positions (i.e., requirement of a high school diploma) create opportunities for career advancement by pursuing additional college credits or an Associate's Degree at nearby Southwest Mississippi Community College.

Table 9: Educational Attainment Level Associated with Direct, Indirect, and Induced Jobs

Entry Level Educational Attainment Level	Employee Count	Employee Count Share of Total
Less than a High School Diploma	6.44	5.5%
High School Diploma - or the equivalent (for example, GED)	27.81	23.7%
Post-Secondary Certificate - awarded for training completed after high school (for example, in agriculture or natural resources, computer services, personal or culinary services, engineering technologies, healthcare, construction trades, mechanic and	15.82	13.5%
Some College Courses	7.67	6.5%
Associate's Degree (or other 2-year degree)	16.52	14.1%
First Professional Degree - awarded for completion of a program that: requires at least 2 years of college work before entrance into the program, includes a total of at least 6 academic years of work to complete, and provides all remaining academic r	0.85	0.7%
Bachelor's Degree	28.2	24.0%
Post-Baccalaureate Certificate - awarded for completion of an organized program of study; designed for people who have completed a Baccalaureate degree but do not meet the requirements of academic degrees carrying the title of Master.	1.1	0.9%
Master's Degree	6.58	5.6%
Post-Master's Certificate - awarded for completion of an organized program of study; designed for people who have completed a Master's degree but do not meet the requirements of academic degrees at the doctoral level.	0.26	0.2%
Doctoral Degree	3.91	3.3%
Post-Doctoral Training	2.22	1.9%

Source: IMPLAN© based upon assumptions and data input provided by the Stennis Institute of Government

Table 10 below shows a breakdown of the major categories of direct, indirect, and induced jobs that

Table 10: Employment, Occupation, and Average Salary Income Associated with the Ongoing Operations of the Sharkey-Issaquena Community Hospital

Occupational Code	Occupation	Wage and Salary Employment Full-Time Equivalent	Wage and Salary Income	Average Wage or Salary Income
29-0000	Healthcare Practitioners and Technical Occupations	46.36	$3,769,950.41	$81,319.03
43-0000	Office and Administrative Support Occupations	13.49	$523,040.38	$38,772.45
31-0000	Healthcare Support Occupations	11.97	$387,561.33	$32,377.72
35-0000	Food Preparation and Serving Related Occupations	7.94	$174,623.92	$21,992.94
11-0000	Management/Executive Occupations	5.77	$691,533.59	$119,849.84
53-0000	Transportation and Material Moving Occupations	4.62	$175,410.93	$37,967.73
13-0000	Business and Financial Operations Occupations	4.57	$318,070.49	$69,599.67
41-0000	Sales and Related Occupations	4.25	$162,038.42	$38,126.69
37-0000	Building and Grounds Cleaning and Maintenance Occupations	3.99	$113,953.54	$28,559.78
49-0000	Installation, Maintenance, and Repair Occupations	2.36	$126,833.53	$53,743.02
21-0000	Community and Social Service Occupations	2.16	$115,507.21	$53,475.56
15-0000	Computer and Mathematical Occupations	2.02	$169,145.15	$83,735.22
51-0000	Production Occupations	1.65	$61,690.77	$37,388.35
33-0000	Protective Service Occupations	1.34	$44,805.52	$33,436.96
19-0000	Life, Physical, and Social Science Occupations	0.96	$73,301.26	$76,355.48
25-0000	Educational Instruction and Library Occupations	0.82	$40,938.92	$49,925.51
39-0000	Personal Care and Service Occupations	0.79	$18,548.49	$23,479.10
23-0000	Legal Occupations	0.65	$65,327.28	$100,503.51
47-0000	Construction and Extraction Occupations	0.65	$32,094.71	$49,376.48
27-0000	Arts, Design, Entertainment, Sports, and Media Occupations	0.55	$29,397.12	$53,449.31
17-0000	Architecture and Engineering Occupations	0.36	$30,593.18	$84,981.06
Total		**117.27**	**$7,124,366**	**$60,751.82**

Source: IMPLAN© based upon assumptions and data input provided by the Stennis Institute of Government

will be supported by the ongoing operations of the Sharkey-Issaquena Community Hospital. Only jobs that offer more than 624 hours of work annually (.30 full-time equivalent) are included in Table 10 on page 32; therefore, the data reflects employment of only 117.27 out of the actual total of 141.84 total direct, indirect, and induced jobs (see Table 7 page 30) that will be supported within Sharkey County. The Stennis Institute Research Team used this information to determine if the jobs created by the investment in the reconstruction of the Sharkey-Issaquena Community Hospital would meet the federal standard of creating jobs in low-income communities that provide a "*Living Wage*."

A "*Living Wage*" is defined as the income an individual in a household must earn to cover the cost of their family's minimum basic needs in the place where they live while being self-sufficient from public assistance. The Living Wage Calculator[29] provides geographic-specific costs for food, childcare, health care, housing, transportation, other basic needs – like clothing, personal care items, internet access, and taxes at the county, metro, and state levels. The federal poverty line is a number that is based on three times the cost of a minimum food diet in 1963 (in today's prices)[30] but it does not reflect the true cost of living because many families and individuals working at low-wage jobs earn too low an income to meet the minimum costs of living in their community. The *Living Wage* was originally developed in 2003 to more comprehensively estimate the employment earnings that a full-time worker requires to cover or support the costs of their family's basic needs where they live, without dependency on federal or state subsidies (i.e. public housing, SNAP benefits). In Sharkey County, Mississippi, the Living Wage for one adult is $39,076.[31]

The average annual salary for each occupational category of direct, indirect, and induced job that will be supported by the ongoing operations of the Sharkey-Issaquena Community Hospital is included in Table 10 on page 32; a review of the salaries associated with these jobs demonstrates that the jobs that are created at the hospital and within the region predominantly pay a salary that is equal to, or significantly above the Living Wage for Sharkey County, Mississippi. For example, there are approximately 46 full-time equivalent jobs with an average salary of $81,319 and almost 14 office and administrative support positions with an average salary of $38,772 (Table 10 page 32).

It should be noted that prior to its destruction by an EF-4 tornado on March 24, 2023, there were 120 people directly employed at the Sharkey-Issaquena Community Hospital; overtime, after the hospital is rebuilt, employment may increase to this pre-disaster level. However, the Stennis Research Team uses very conservative assumptions when developing economic impact models to avoid unrealistic projections.

Extended Economic Contribution of Hospitals

Hospitals play a pivotal role in the economy, their contributions extend beyond direct, indirect, and induced employment, income, and value-added. Beyond the effects captured in econometric input-output models, hospitals help maintain a healthy workforce; this reduces absenteeism, improves worker productivity, and increases GDP. [32, 33]

Hospitals also play a vital role in community development, acting as economic anchors that attract other businesses and industries.[34] They contribute to the local tax base through property and sales taxes, and their presence can enhance regional attractiveness by providing wellness or exercise centers making rural areas more attractive for business relocation.[35, 36]

[29] Amy K. Glasmeier, "Living Wage Calculator," Massachusetts Institute of Technology, 2025. Accessed on March1, 2025], https://livingwage.mit.edu/counties/28125
[30] U.S. Census Bureau, "How the Census Bureau Measures Poverty," November 22, 2021https://www.census.gov/topics/income-poverty/poverty/guidance/poverty-measures.html
[31] Amy K. Glasmeier, "Living Wage Calculator," Massachusetts Institute of Technology, 2025. Accessed on March1, 2025], https://livingwage.mit.edu/counties/28125
[32] Cronin, C. E., Franz, B., & Schuller, K. A. (2021). Expanding the population health workforce: strategic priorities of hospital organizations in the United States. Population Health Management, 24(1), 59-68.
[33] Asay, G. R. B., Roy, K., Lang, J. E., Payne, R. L., & Howard, D. H. (2016). Absenteeism and employer costs associated with chronic diseases and health risk factors in the US workforce. Preventing chronic disease, 13, E141.
[34] Rosenbaum, S. (2016). Hospitals as community hubs: Integrating community benefit spending, community health needs assessment, and community health improvement. Economic Studies at Brookings, 5.
[35] Shortell, S. M., Washington, P. K., & Baxter, R. J. (2009). The contribution of hospitals and health care systems to community health. Annual review of public health, 30(1), 373-383.
[36] Parrillo, A. J., & De Socio, M. (2014). Universities and Hospitals as Agents of Economic Stability and Growth in Small Cities: A Comparative Analysis. Industrial Geographer, 11.

Community Engagement by Hospitals

The dynamic between a hospital and the local community also includes multiple initiatives that benefit residents of low-income communities. Hospitals are sponsors of local events, donate medical supplies, and collaborate with local business to promote health fairs, healthy living workshops, and health related activities at local schools.

In summary, hospitals contribute economically to the local community through job creation, the extensive purchase of goods and services, stimulation of the local economy, providing economic stability, and maintaining community vitality. This underscores the importance of rebuilding the Sharkey-Issaquena Community Hospital as a key economic anchor in the community.

Vulnerable Populations

The Sharkey-Issaquena Community Hospital meets the healthcare needs of federally defined vulnerable populations to include older adults, persons with disabilities (mental, physical, developmental); persons with alcohol or other substance-use disorders; and persons with HIV/AIDS and their families. For Example:

- There are 8,051 (3,136 households) people living within a 30-minute drive time from the proposed site of the Sharkey-Issaquena Community Hospital (Table 11 below). Among the 3,136 households that live within the 30-minute service area of the hospital — 38.9 percent of households (1,219 households) are low-income and 52.3 percent of households (1,639 households) are in the Middle Tier of income (Table 11 below).
- There are approximately 2,345 people over the age of 65 that live within a 45-minute drive time from the proposed site of the Sharkey-Issaquena Community Hospital (Table 12 page 35).

Table 11: 2024 Population and Household Income Distribution for Selected Drive Times from the Sharkey-Issaquena Community Hospital Site

2024 Population and Income Distribution based upon Drive Time from the Sharkey-Issaquena Community Hospital Site						
Summary	**15 Minutes**		**30 Minutes**		**45 Minutes**	
Population	2,970	N/A	8,051	N/A	30,107	N/A
Households	1,232	N/A	3,136	N/A	10,239	N/A
Median Age	43.6	N/A	41.7	N/A	39.7	N/A
Average Household Size	2.29	N/A	2.39	N/A	2.43	N/A
	# Households	**Percent**	**# Households**	**Percent**	**# Households**	**Percent**
Household Income Base	1,232	100%	3,136	100%	10,239	100%
<$15,000	204	16.6%	700	22.3%	2,178	21.3%
$15,000-$24,999	230	18.7%	494	15.8%	1,517	14.8%
$25,000-$34,999	129	10.5%	298	9.5%	1,286	12.6%
$35,000-$49,999	74	6.0%	315	10.0%	1,393	13.6%
$50,000-$74,999	240	19.5%	533	17.0%	1,520	14.8%
$75,000-$99,999	81	6.6%	263	8.4%	863	8.4%
$100,000-$149,999	227	18.4%	374	11.9%	888	8.7%
$150,000-$199,999	16	1.3%	91	2.9%	358	3.5%
$200,000+	30	2.4%	68	2.2%	237	2.3%
Median Household Income	$44,881	N/A	$37,891	N/A	$36,104	N/A
Average Household Income	$62,346	N/A	$57,591	N/A	$56,155	N/A
Per Capita Income	$25,723	N/A	$22,992	N/A	$19,896	N/A
Income Balance	**# Households**	**Percent**	**# Households**	**Percent**	**# Households**	**Percent**
Households in Low Income Tier	445	36.1%	1,219	38.9%	3,801	37.1%
Households in Middle Income Tier	668	54.2%	1,639	52.3%	5,562	54.3%
Households in Upper Income Tier	119	9.7%	278	8.9%	876	8.6%
Income Balance Ratios:	**Sharkey Site**	**U.S. Average**	**Sharkey Site**	**U.S. Average**	**Sharkey Site**	**U.S. Average**
P90-P10 Ratio	13.2	12.5	17.8	12.5	16.7	12.5
P90-P50 Ratio	2.7	2.6	3.2	2.6	3.3	2.6
P50-P10 Ratio	5.0	4.7	5.6	4.7	5.1	4.7
80-20 Share Ratio	20.1	12	22.0	12	17.2	12
90-40 Share Ratio	3.8	3	4.1	3	3.6	3

Data Note: *2024 household income represents an estimate of annual income as of July 1, 2024.*
Source: *Esri forecasts for 2024 based on U.S. Census Bureau American Community Survey Data.*

- People living in Sharkey and Issaquena Counties have elevated rates of physical and mental distress; Sharkey residents also have more days per month of poor mental and physical health as compared to these levels in the United States and the State of Mississippi (Table 5 page 26).
- The Sexually Transmitted Infections cases per 100,000 population in Sharkey County is approximately 40 percent higher than that of the United States (1,283.1 in Sharkey County as compared to 495.5 in the United States (Table 5 page 26).

Income Balance Ratios

The distribution of income is frequently used to measure the depth of poverty or the degree of income inequality (see Table 11 on page 34). Economists typically define the "*middle class*" as the middle 60 percent of earners.[37] ESRI software provides geographic specific interdecile ratios of income distribution to quantify the spread of incomes across households. ESRI provides the following ratios of interdecile income distribution:

- P90-10 ratio – Dollars earned by the household at the 90th percentile to the dollars earned by the household at the 10th percentile; this compares the top 10% of the distribution to the bottom 10 percent.
- P90-50 ratio – Dollars earned by the household at the 90th percentile to the dollars earned by the household at the 50th percentile; this compares the top 10 percent of the distribution to the median of the distribution.
- P50-10 ratio – Dollars earned by the household at the 50th percentile to the dollars earned by the household at the 10th percentile; this compares the median to the bottom 10 percent of the distribution.

As noted by ESRI documentation regarding income ratios "*the P90-10 ratio quantifies an area's equality gap, but it provides little information about the middle section of the income distribution. The P90-50 and P50-10 ratios provide more information; the P90-50 ratio summarizes inequality above the median, while the P50-10 ratio summarizes inequality below the median. The product of the P90-50 and P50-10 ratios is the P90-10 ratio.*"[38]

As shown in Table 11 on page 34, the population within a 30-minute drive time from the proposed site of the Sharkey-Issaquena Community Hospital indicate a low-income predominance in every measure of Income Balance Ratio (IBR), and when the IBR for the Sharkey Hospital service area is compared the IBR for the United States, these Income Balance Ratios are greater than national average Income Balance Ratios indicating that differences in income inequality within the area that will be served by the Sharkey-Issaquena Community Hospital are greater than the average income inequality exhibited in the United States.

Table 12: 2024 Household Income and Age of Householder within Selected Drive Times from the Proposed Sharkey-Issaquena Hospital Site

2024 Households by Income and Age of Householder							
Age Group	**<25**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**
15 Minute Drive							
# Households	42	143	172	171	233	287	183
Household with Income Base < $25,000	47.7%	29.4%	33.7%	25.1%	35.2%	35.5%	48.1%
30 Minute Drive							
# Households	105	367	450	478	639	648	449
Household with Income Base < $25,000	49.5%	32.9%	33.3%	27.0%	41.0%	39.4%	50.1%
45 Minute Drive							
# Households	306	1,267	1,601	1,650	2,051	2,021	1,344
Household with Income Base < $25,000	47.1%	34.8%	32.4%	27.9%	36.3%	37.8%	46.5%

Source: Esri forecasts for 2024 derived from U.S. Census American Community Survey Data

[37] Estache, Antonio and Danny Leipziger. eds. (2009). Stuck in the Middle: Is Fiscal Policy Failing the Middle Class? Washington, DC: Brookings Institution Press.
[38] Esri Data Development (2024). Esri Income Tiers and Measures of Income Inequality 2024 - 2029 Esri Methodology Statement, revised. https://storymaps.arcgis.com/stories/1f571b2a9a1e4a4dabbf709fbbaef624

Underserved Communities

The communities served by The Sharkey-Issaquena Community Hospital meet the clear definition of communities that were economically distressed before the disaster as described below:

- Sharkey County and Issaquena Counties are designated as High Needs Health Professional Primary Care Shortage Areas (HPSA) by the U.S. Department of Health and Human Services (HPSA ID 1283329254) with an HPSA Score of 22[39] and an PCMCTA Score of 22.[40] Within Sharkey County and Issaquena County (HPSA Geography Identification # 28125 and #28055, respectively) 33.1 percent of the population was identified by HHS as being below 100% poverty; the HPSA Formal Ratio was 5362:1[41] and the HPSA designated population was 5,630.[42]
- The new Sharkey-Issaquena Community Hospital will be constructed in Census Tract 28125950100 a qualifying New Market Tax Credit census tract (Table 13 at right). This meets the distress criteria established for the designation of an investment area of a Community Development Financial Institution at 12 CFR 1805.201(b)(3)(ii)(D).

Table 13: Hospital Site is in a Qualifying New Market Tax Credit Census Tract 28125950100

Census Tract 28125950100	
Metro Designation	Non-metro
Poverty Rate	30.5%
Pct Median Family Income	88.0%
Unemployment Rate	7.7%
Poverty Rate Qualified	Yes
MedianIncomeQualified	No
NMTCQualified	Yes
CountyCode	28125
StateName	Mississippi
CountyName	Sharkey County
Unemployment Rate Ratio	1.43
Ratio Qualified	No
PovertyPopulation	2,260

Source: U.S. Department of the Treasury Community Development Financial Institutions Fund CIMS Mapping Tool https://cimsprodprep.cdfifund.gov/CIMS4/apps/pn-nmtc/index.aspx#?entity=CT_2016_2020_NMTC_ELIGIBLE,28125950100&center=-90.887855,32.903961&level=14&tool=legend&visible=CT_2016_2020_NMTC_ELIGIBLE

The closure of a local hospital can have dire repercussions, including increased unemployment, reduced access to healthcare, and greater reliance on government social programs. Multiple studies have found that the closure of hospitals in rural areas have "strong and sharp negative effects on local employment levels."[43] Failure to rebuild the Sharkey-Issaquena Community Hospital will have sweeping negative effects on the health of over 8,000 people within a 30-minute drive time from the hospital. The closure of a hospital has sweeping negative effects with broad negative economic impacts; a recent working paper from Vogler (2021) reports that rural hospital closures negatively impact local labor markets.[44]

Project Meets All Requisite Criteria for Utilization of CDBG-DR funds

The reconstruction of the Sharkey-Issaquena Community Hospital meets all the requisite criteria for the utilization of CDBG-DR funds:

a) It directly ties back to the Presidentially Declared Disaster FEMA-4697-DR because the hospital was destroyed by a tornado and is required to provide healthcare and emergency response during future disasters.
b) All funds will be used in a HUD-Designated MID Area (Sharkey County and Zip Code 39159)

[39] HPSA Score: This attribute represents the Health Professional Shortage Area (HPSA) Score developed by the National Health Service Corps (NHSC) in determining priorities for assignment of clinicians. The scores range from 0 to 26 where the higher the score, the greater the priority.
[40] PC MCTA Score: This attribute represents the Maternity Care Target Areas (MCTA) supplementary score. MCTA Supplementary Scores are only available for Primary Care Health Professional Shortage Areas (HPSAs).
[41] HPSA Formal Ratio: This attribute represents the ratio of the Health Professional Shortage Area (HPSA) Designation Population to HPSA provider full-time equivalents displayed in ratio format (for example, 3500:1), where the population and the designation share the same discipline class (for example, Primary Care, Dental Care, and Mental Health).
[42] U.S. Department of Health & Human Services, Health Resources & Services Administration Health Professional Shortage Areas. https://data.hrsa.gov/data/download.
[43] Alexander, D. and Richards, M. R. (2023). Economic Consequences of Hospital Closures. Journal of Public Economics. https://doi.org/10.1016/j.jpubeco.2023.104821.
[44] Vogler, Jacob, 2021. Rural Hospital Closures and Local Economic Decline. SSRN Working Paper Series. Posted 9 March 2021. https://ssrn.com/abstract=3750200.

c) Benefit low- and moderate-income persons – the construction of the hospital qualifies for CDBG assistance because all health care services will benefit all the residents of a primarily residential area where at least 51 percent of the residents are low- and moderate-income persons — see Table 14 at right

d) The hospital will meet an urgent community need that poses a serious and immediate threat to health by providing health care and hospital services in a rural area where the closest hospital facility is more than 45 minutes away and the hospital is needed to provide response and recovery during emergency and disaster events.

e) At the current time no other funding is available

Table 14: HUD CDBG LMI

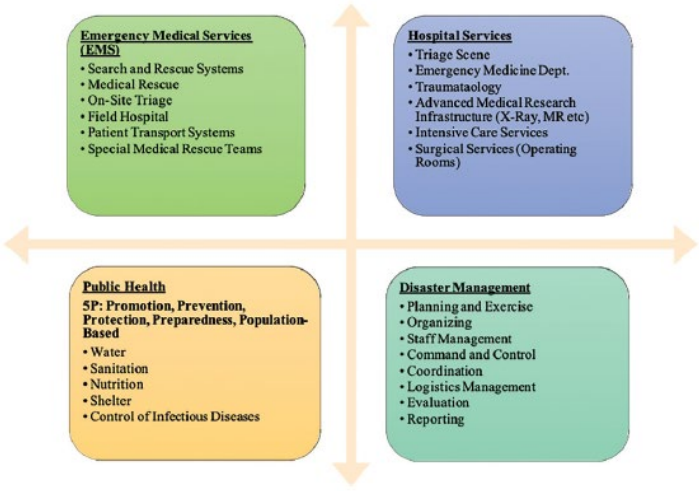
HUD CDBG LMI for Mississippi MID Designated Areas					
	Low	Low Mod	LMMI	LOWMOD UNIVERSE	LOWMOD Percent
Hinds County	71,800	114,820	157,735	226,730	50.60%
Humphreys County	3,310	5,100	6,240	8,105	62.90%
Belzoni	850	1,205	1,590	2,080	57.90%
Silver City	160	250	300	365	68.50%
Jackson County	34,875	58,930	89,365	141,635	41.60%
Moss Point	4,250	6,540	9,615	13,275	49.30%
Monroe County	7,895	14,420	20,595	35,065	41.10%
Amory*	1,720	2,520	3,515	6,650	37.90%
28095950400		2,185		3,575	61.12%
Block Group 1 Tract 9504	380	550	570	720	N/A
Block Group 3 Tract 9504	510	710	760	1,425	N/A
Subtotal	**890**	**1,260**	**1,330**	**2,145**	**62.00%**
Scott County	8,690	12,660	17,240	28,000	45.20%
Sharkey County	1,175	2,230	3,005	4,285	52.00%
Rolling Fork	430	1,205	1,570	2,195	54.90%

Source: HUD Low- and Moderate-Income Area Data, based on 2016-2020 ACS https://experience.arcgis.com/

* See Alternative Considerations on following pages

The reconstruction of the Sharkey-Issaquena Community Hospital is directly aligned with long-term recovery goals by enhancing community resilience. The hospital will fulfill the CDBG-DR national objective of benefiting LMI persons while mitigating the recurring threat of tornado-related displacement and loss. By replacing the health care services capacity lost in the disaster due to the destruction of the Sharkey-Issaquena Community Hospital, rebuilding the hospital will address the health care needs that have been documented in the prior pages of this assessment and provide health care services to vulnerable residents who will be left without access to health care. The rebuilding of the hospital is tied directly to the impacts of the HUD identified Most Impacted and Distressed areas that were impacted by tornado events associated with Disaster Declarations FEMA-4697-DR, FEMA-4727-DR, and FEMA-4790-DR for which CDBG-DR funds have been allocated to the State of Mississippi, meeting both immediate safety needs and future preparedness mandates.

Illustration 1: FEMA Model for Hospital Disaster Response



As shown in Illustration 2 at right, hospitals must be prepared to meet a range of health care and emergency response needs during a disaster. Hospital resilience is the capacity of hospitals to withstand, assimilate, and respond to the impacts of critical situations, all while ensuring the uninterrupted delivery of essential healthcare services.[45] Creating resilience within the health system is a crucial stage in health disaster management, as it enables the continued provision of healthcare services. Hospitals and their personnel may become victims of disasters when their services are most deeply needed.[46] Health care is the most needed service required during and after a disaster. Resilient hospitals and safe patient transport systems are necessary to treat injuries and prevent deaths.

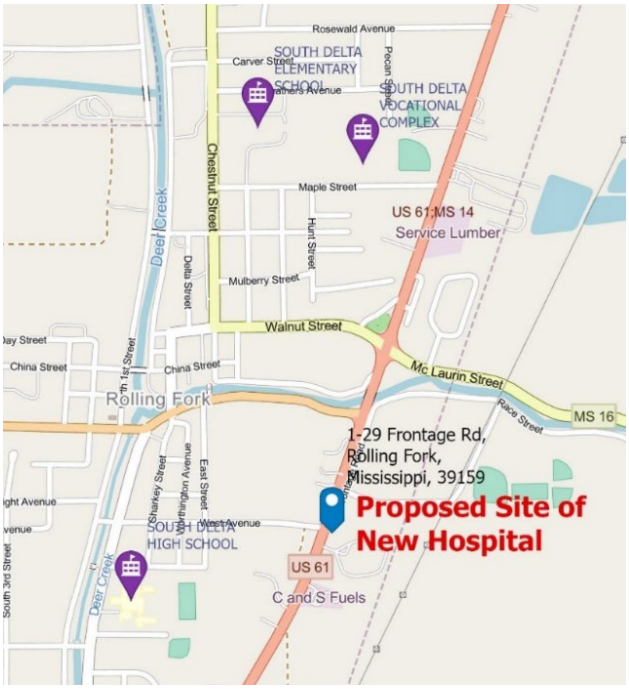
[45] Seyghalani Talab, F., Ahadinezhad, B., & Khosravizadeh, O. (2024). Investigating the Organizational Resilience of hospitals during emergencies and disasters: a Comprehensive Review of the components. Health in Emergencies and Disasters Quarterly, 9(3), 159-172.

[46] Ali Ardalan, Catherine Y. Ordun, James Michael Riley, Chapter 2 - Public Health and Disasters, Editor(s): Gregory R. Ciottone, Ciottone's Disaster Medicine (Second Edition), Elsevier, 2016, Pages 6-12, ISBN 9780323286657, https://doi.org/10.1016/B978-0-323-28665-7.00002-9. (https://www.sciencedirect.com/science/article/pii/B9780323286657000029)

Because it is critical to preserve the ability of the health care system to provide essential functions during and after a disaster, the first step in the rebuilding process is to assure that the physical infrastructure of the hospital can withstand disaster events; in Sharkey County this means building a hospital with the structural strength to withstand a tornado and continue to provide health care services during and after a storm.

Additional factors have been incorporated into the planning process for the rebuilding of the Sharkey-Issaquena Community Hospital to enable the hospital to provide uninterrupted health services during future emergency events. The planning process recognized that in addition to structural damage affecting the ability of the hospital to continue operations during a disaster, damage to nonstructural components, such as electricity, water, heating and ventilation systems, and medical equipment can impede the delivery of health care services during and post-disaster.

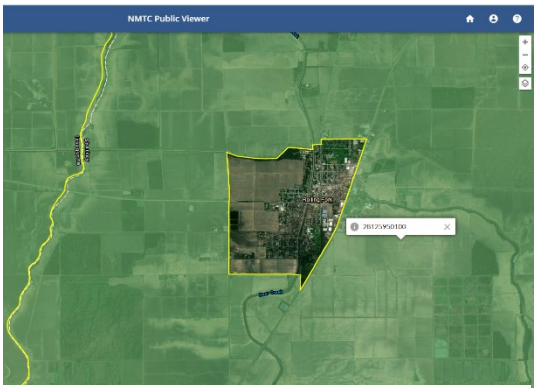
- Health care facilities are uniquely dependent on the continuous supply of electrical power. Losing such a supply immediately puts at risk the lives of patients, staff members, and other personnel in the facility. Carefully conceived and comprehensive backup plans and procedures are absolutely critical to protect all of these individuals. Advance planning, frequent and robust rehearsals, strong, dedicated leadership, collaboration with outside agencies and facilities, and ongoing commitment from staff members are critical for a positive outcome from disaster events. The purchase of generators is included in the cost of rebuilding the hospital.
- The site location is in close proximity to the schools located in Rolling Fork (see Map 2 at right). The South Delta High School at 303 Parkway Avenue, with an enrollment of 170 students with 14 classroom teachers, is within a 5-minute walk from the proposed hospital site; South Delta Elementary School is within a 3-minute drive from the site. The South Delta Middle School (not shown on the map) is located on Delta Middle School Road in Anguilla, Mississippi, which is approximately 5.8 miles (a 6-minute drive) from the proposed hospital site.



Map 2: Proximity of Hospital Site to Area Schools

The new hospital will be built to comply with all HUD and FEMA Guidelines, including compliance with ICC-500 standards.

All designs will be reviewed by a licensed structural engineer familiar with ICC-500 to ensure compliance with all HUD and FEMA guidelines. This includes adhering to federal regulations, such as those in the HUD Consolidated Notice or Universal Notice, which may impose specific standards like elevation requirements in flood-prone areas, accessibility standards, or the incorporation of mitigation measures to enhance resilience against future disasters. The planning process, building designs, and implementation of plans will conform to recommendations and guidelines as required by FEMA P-361 Safe Rooms for Tornadoes and Hurricanes: *Guidance for Community and Residential Safe Rooms*. The spaces will be in compliance with the *Americans with Disabilities Act*, including wheelchair space sufficient to accommodate community need as identified during the community assessment. The community safe rooms will be constructed to include the use of steel



Map 3: Proposed Hospital Site in NMTC Qualifying Census Tract 28125950100

exterior doors, frames, and offset doors to prevent assault from flying projectiles as required by the FEMA publication P-361, Design and Construction Guidance for Community Safe Rooms which are highly likely to protect occupants from injury or death by meeting or exceeding the design standards of the International Code Council (ICC)/National Storm Shelter Association (NSSA) 500 Standard for the Design and Construction of Storm Shelters. These safe rooms will meet the minimum requirements for Operations and Maintenance plans as described in the most current edition of FEMA's Hazard Mitigation Assistance (HMA) Unified Guidance. The FEMA HMA Unified Guidance is updated periodically; the most current HMA Unified Guidance are available at: https://www.fema.gov/hazard-mitigation-assistance.

Considerations given to analysis of a new hospital, included the assumption that the new building should be constructed using building materials able to withstand high wind; additional consideration was given to compliance with:

- Infrastructure Planning and Design (87 FR 6374).
- CDBG-DR funds as match (87 FR 6375) Grant funds may be used to satisfy a match requirement, share, or contribution for any other federal program when used to carry out an eligible CDBG-DR activity.
- Prioritizing economic revitalization assistance—alternative requirement (87 FR 6375)
  New: Priority used to be focused on small businesses, now grantees must prioritize assistance to disaster-impacted businesses that serve underserved communities and spur economic opportunity for underserved communities that were economically distressed before the disaster.
  •HUD define underserved communities
  •Grantees must maintain supporting documentation to demonstrate how they prioritized underserved communities for purposes of these activities

National objective documentation for activities that support economic revitalization (87 FR 6375)

- Same alternative requirements as prior notices: Grantees may identify the LMI jobs benefit by documenting, for each person employed, the name of the business, type of job, and the annual wages or salary of the job.
- An impact and unmet needs assessment (87 FR 6380)
- Grantees must develop an assessment to understand the type and location of community needs and to target limited resources to those areas with the greatest need.
- Grantees must also include the costs of incorporating hazard mitigation measures to protect against the specific identified impacts of future extreme weather events and other natural hazards.
- The analysis should factor in historical and projected data on risk that incorporates best available science.

Extended Stay Hotel Element

There is a range of extended-stay hotel models (see Table 15 below). Two of the highest performing economy extended-stay hotel models, WoodSpring Suites (Choice) or ECHO Suites by Wyndham, are supported by market analysis. Generally, the extended stay market is outperforming other hotel industry segments, with strong RevPAR (Revenue Per Available Room) performance.

Table 15: Economy and Midscale Extended-Stay Hotel Operators

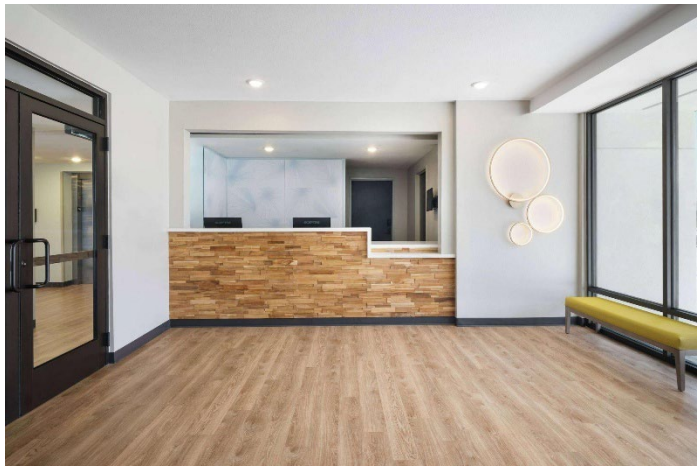
Economy Extended Stay Brands			Midscale Extended Stay Brands		
Brand	**Parent Company/ Chain**	**Key Features**	**Brand**	**Parent Company/ Chain**	**Key Features**
WoodSpring Suites	Choice Hotels	Affordable studios, full kitchens, pet-friendly options	Everhome Suites	Choice Hotels	Modern suites, full kitchens, 24-hour market, fitness centers
Extended Stay America	Extended Stay America	Basic suites, full kitchens, weekly housekeeping	MainStay Suites	Choice Hotels	Apartment-style, weekly housekeeping, free WiFi
Suburban Studios	Choice Hotels	Simple, value-focused suites, on-site laundry	StudioRes	Marriott	Studios with kitchens, fitness, laundry; pet-friendly
ECHO Suites Extended Stay	Wyndham Hotels	Efficient new-build design, kitchens, low staffing	LivSmart Studios	Hilton	Lower-midscale, full kitchens, grab-and-go options
InTown Suites	Independent	Long-term focus, basic amenities	Home2 Suites	Hilton	Upper-midscale feel with kitchens, breakfast, pet-friendly

Source: STR Chain scales, J.D. Power Reports, corpaylodging.com, forbes.com, upgradedpoints.com, altexsoft.com

The ECHO Suites Conceptual Model (all photos are from the ECHO Suites at Johnson City Medical Center in Tennessee)

Wyndham has emphasized that the brand's design and efficient operations are intended to provide high returns for franchisees. The ECHO Suites hotel design is a purpose-built, new construction prototype optimized for operational efficiency, high revenue-generating square footage, and designed to meet the needs of long-term guests. The design focuses on essential amenities and minimizing labor costs.

Image 3: Lobby



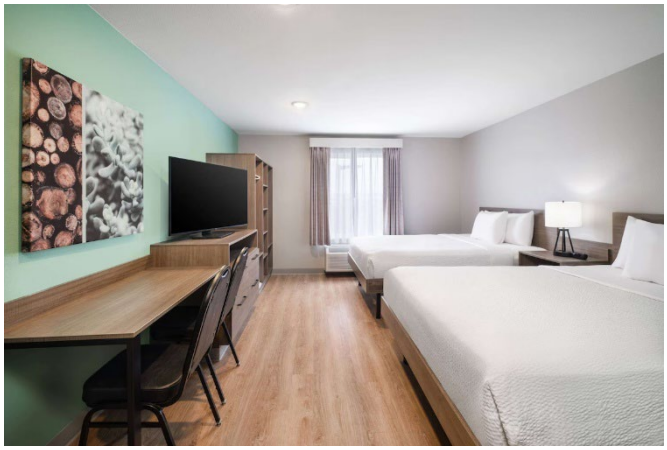
Key Design Features

Room Design and Amenities:

- **Studio Suites:** The prototype features 124 single- or two-queen studio suites, each averaging around 300-312 square feet.

- **Fully Equipped Kitchens:** Every suite includes a kitchen with a full-size refrigerator, microwave, electric cooktop, and dishwasher.
- **High Rentable Space:** Approximately 79% of the hotel's total square footage is revenue-generating, which is among the highest in the industry.
- **Labor-Saving Design:** Public spaces like the lobby, fitness center, and 24/7 guest laundry are efficiently designed to limit staffing needs. A glass wall and locked door separate the front desk from the lobby after hours, allowing key access for late-night guests without requiring overnight staff.
- **Operational Efficiency:** design decisions are made to minimize labor and operational costs. For example, the use of luxury vinyl tile flooring is more affordable and easier to maintain than carpet. The concept caters to guest seeking residential-style accommodations; the lobby is modern but with a focus on comfort and functionality the public space is purposefully kept minimal.
- **Construction Efficiency:** The design uses standard-sized building materials to minimize waste and labor costs (e.g., 8-foot ceilings use standard four-by-eight foot drywall sheets).
- **Minimalist Public Spaces:** The design intentionally eschews non-essential amenities like meeting rooms, pools, or outdoor grills to focus on core guest needs and keep operating costs down.
- **Lobby Features:** 24-hour front desk staffed to assist guests with check-in, check-out, and other services; vending machines.
- **Amenities:** A fitness center, 24/7 guest laundry, free parking, EV charging stations

Below photos from ECHO Suites Extended Stay by Wyndham Johnson City Medical Center in Tennessee



30-Room Extended Stay Hotel Cost of Construction as Free-Standing Project

Based on 2025 industry data from 2025 HVS U.S. Hotel Development Cost Survey, which analyzes actual development budgets for hotels proposed or under construction in 2024, an economy extended-stay hotel aligns closely with the "midscale extended-stay" category (e.g., brands like WoodSpring Suites, Home2 Suites, or TownePlace Suites, which offer budget-friendly options with kitchenettes and basic amenities). This category provides the most relevant benchmark for an economy-level property. The median total development cost is approximately $170,000 per room, including land acquisition. Excluding land reduced this estimate to about $157,000 per room. For a 30-room hotel, this equates to a total estimated cost of approximately $4.71 million. Note that this is a national U.S. average and can vary 20-30% based on factors like location (e.g., higher in urban/coastal areas), inflation, labor availability, and specific design choices. Smaller properties like a 30-room hotel may incur slightly higher per-room costs (e.g., +10 to 15%) due to fixed expenses being spread over fewer rooms, potentially pushing the total toward $5 to $5.3 million in some cases.

This estimate includes:

- Hard costs (building and site improvements, such as construction, materials, labor, and utilities).
- Soft costs (architectural/engineering fees, permits, legal fees, environmental assessments, impact fees, financing fees, insurance, and contingencies).
- FF&E (furniture, fixtures, and equipment, including kitchenettes, bedding, appliances, and common-area setups).
- Pre-opening and working capital (staff training, marketing, initial supplies, and operational setup).
- Developer fees (overhead for project management).

The estimate excludes land acquisition, ongoing operational costs post-construction, and any unique customizations (e.g., eco-friendly upgrades or enhanced tech).

The estimated construction costs presented in Table 16 on page 43; is slightly higher than the estimate of $93,000 to $113,000 per key, excluding land and development costs that is provided for ECHO Suites Extended Stay by Wyndham. The Stennis Institute selected to develop investment scenarios based on the higher range of estimated costs, rather than the lower range of costs.

Table 16: Estimated Construction Cost for 30-Room Extended-Stay Hotel

Category	Per-Room Cost	Total for 30 Rooms	Approximate % of Total	Description
Building & Site Improvements (Hard Costs)	$114,000	$3,420,000	73%	Core construction, materials, labor, site prep, parking, landscaping, and utility connections.
Soft Costs	$17,000	$510,000	11%	Design/engineering, permits, inspections, legal, financing, insurance, and all associated fees (e.g., zoning, environmental, impact).
FF&E	$17,000	$510,000	11%	Furnishings, kitchen appliances, linens, TVs, and equipment for rooms and common areas like laundry or lobby.
Pre-Opening & Working Capital	$3,000	$90,000	2%	Initial marketing, staff hiring/training, utilities setup, and reserves for early operations.
Developer Fee	$5,000	$150,000	3%	Project oversight, consulting, and administrative fees.
Total (Excluding Land)	**$157,000**	**$4,710,000**	**100%**	**Rounded national median estimate.**

Source: HVS U.S. Development Cost Survey, July 17,2025 by Luigi Major, MAI https://www.hvs.com/article/10219/hvs-us-hotel-development-cost-survey-2025/, https://x.ai, and https://copilot.microsoft.com/.

Financing Options for Hotel Development[47]

Financing a hotel project, such as a 30-room economy extended-stay property (with estimated costs around $4.7 million excluding land), typically involves a mix of debt, equity, or government-backed options. In the event the decision is made not to pursue the use of New Market Tax Credits, alternative sources for financing a small extended-stay hotel are discussed in this section. Common sources include banks, private lenders, and specialized hospitality financiers. Key factors influencing approval include a strong business plan with revenue projections (e.g., based on occupancy rates and RevPAR), a minimum 20% down payment, credit ratings, and evidence of market demand.

For new construction, loans often cover land acquisition, building costs, FF&E, and pre-opening expenses, but expect higher scrutiny due to operational risks in the hospitality sector. Table 16 on page 44 summarizes primary options suitable for hotel construction or development, drawing from industry standards. Terms are approximate national averages for 2025; actuals depend on creditworthiness and project specifics.

[47] Not included in this investment scenario is the option to set aside several hotel rooms for use by staff or by individuals who are engaged in workforce training activities at the facility to permit the use of Low-Income Housing Tax Credits. For example, low-income people that are enrolled in nurse training programs at the hospital or hospitality/tourism training programs could live in the extended stay hotel rooms; setting aside 13 rooms for LIHTC at 4% might generate ± $1.2 million from the sale of credits. This requires meeting compliance requirements. Alternatively, individual units might be structured for condominium ownership by participating physicians and healthcare providers.

Table 17: Sources of Funding for Extended Stay Hotels

Option	Description	Typical Terms	Pros	Cons	Eligibility/Notes
SBA 7(a) Loans	Government-guaranteed loans through banks for flexible use, including construction, acquisition, or working capital. Popular for small hoteliers starting or expanding.	Up to $5M; 7–25-year repayment; interest 7-10% (prime + 2-3%); up to 85-90% LTV.	Low rates: flexible fund use (e.g., can cover soft costs); long terms reduce monthly payments.	Slower approval (6-8 weeks); requires SBA review; limited to US small businesses (net worth < $15M, avg. net income < $5M).	US citizens/residents; good credit; detailed business plan with 2+ years projections; ideal for 30-room economy hotels as it supports smaller scales.
SBA 504/CDC Loans	Backed by SBA and non-profits for fixed-asset purchases like land, construction, or equipment. Often for community development projects.	Up to 90% financing ($1M+); 10–30-year terms; fixed rates 5-7%; pre-approval in 48 hours, closing in 6 weeks.	High leverage (low down payment); fixed low rates; supports revitalization (e.g., extended-stay in underserved areas).	Multi-party process slows approval; cannot fund operations (e.g., salaries); paperwork intensive.	Businesses with <500 employees; focus on job creation; suits new builds with green features; 20% equity is often required for small projects.
Commercial Mortgages/Permanent Loans	Long-term bank or lender loans for property acquisition and construction, secured by the hotel itself.	$1M+; up to 75% LTV; 20–30-year amortization; rates 6-9%.	Stable long-term funding; amortizes slowly; can roll into from construction loans.	Higher rates for hospitality risk; strict underwriting (e.g., RevPAR forecasts).	Strong credit (700+); 25%+ equity; proven management team; good for flagged brands (e.g., economy extended-stay like WoodSpring).
Bridge Loans	Short-term financing to bridge gaps during construction or until permanent funding is secured.	$1M+; 1–3-year terms; rates 8-12%; funding in 3-7 days.	Quick access for time-sensitive needs (e.g., land purchase); flexible.	Higher rates: short repayment (refinance needed); interest-only often.	Existing assets/equity; for transitional phases in new builds; useful if awaiting SBA approval.
Private Lenders/Mezzanine Financing	Debt or equity from private investors or funds for higher-risk elements, are often subordinate to senior loans.	$500K+; 3–10-year terms; rates 10-15%; up to 80-90% combined LTV.	Faster approval; non-recourse options; fills equity gaps.	Costlier; potential equity dilution; less regulated.	Experienced developers; strong project viability; suits new economy hotels with unique appeals (e.g., extended-stay in growing markets).
Asset/Equipment Financing (FF&E Loans)	Loans for furniture, fixtures, equipment, and renovations, often for PIPs in branded hotels.	$1M-$5M; up to 75% LTC; 5–10-year terms; rates 7-10%.	Targets specific needs (e.g., kitchenettes in extended-stay); preserves cash.	Asset-secured (repossession risk); not for full construction.	Operational history preferred; for add-ons in new builds.
Crowdfunding/Equity Partners	Raise funds from multiple investors via platforms or wealth managers for equity stakes.	Varies ($100K+); no fixed repayment (equity-based); returns via profits.	No debt burden; accesses diverse investors; good for unique projects.	Dilutes ownership; marketing effort required; regulatory hurdles.	Mission-driven or innovative hotels; online platforms like Fundrise; less common for pure construction.
Government Grants/Aid	Non-repayable funds for qualifying projects, often tied to economic development or sustainability.	Varies by program; no repayment; application based.	Free money; supports underserved areas.	Competitive; limited availability; strict criteria.	Entrepreneurs in targeted zones (e.g., Opportunity Zones); pair with loans for economy hotels.

Sources:
The Hotel Funding Handbook by Avana Capital, August 2025. https://avanacapital.com/hospitality-lending/hotel-funding/
Hotel Financing: Your Complete Guide to Funding and Investment, June 2025. SiteMinder. https://www.siteminder.com/r/hotel-financing/

Market Analysis for Extended Stay Hotel

Rolling Fork, a small rural town in Sharkey County, Mississippi, presents a niche opportunity for an economy extended-stay hotel due to its limited existing accommodations, ongoing recovery from the 2023 tornado, and position in the Mississippi Delta region. The local economy is primarily driven by agriculture and healthcare. Demand for extended-stay lodging could stem from disaster recovery workers, seasonal agricultural labor, eco-tourism, and business travelers along U.S. Highway 61 (the Blues Highway). The site is situated directly on Highway 61 with a 48-hour traffic count of 4,800 vehicles. By positioning the hotel adjacent to the Sharkey-Issaquena Community Hospital, enhances market capture of health care service providers (physicians and staff leasing medical retail spaces), visitors to hospital patients, and traveling health care product and services vendors. Additional demand for extended-stay lodging could stem from eco-tourists visiting area wildlife management areas, seasonal agricultural labor, and government workers.

Synthesis of Market Data

- Rolling Fork's population stands at about 1,409 in 2025, down from 2,001 in 2023 with a -4.4% annual decline, making it a small town.
- The town's demographics show 78.81% Black residents and 21.19% White, with a median income of $34,375 and a poverty rate of 26.3%. Gender distribution skews slightly female (55.9%).
- The local economy relies heavily on agriculture like cotton, soybeans, corn, and timber with key industries including health care, retail, and transportation.
- Competition in Rolling Fork remains limited, with only one basic motel in town. The trip from Leland, Mississippi to Vicksburg (closest hotels to Rolling Fork) is 1 hour and 39 minutes. Alternatively, the travel time between the Hampton Inn in Greenville to the LaQuinta Inn in Vicksburg would be 1 hour and 27 minutes. Major competitors are at minimum 30 to 40 miles away from the proposed site.

Image 4: The Only Existing Motel in Rolling Fork at 21015 U.S. 61

- Business and Transient Travel: Rolling Fork is the county seat of Sharkey County in the Mississippi Delta. The County Courthouse and the presence of the Board of Supervisors of Sharkey County stimulate significant business and legal activity.
- Tourism and Cultural Attractions: The site is situated directly on U.S. Highway 61 (the Blues Highway) traversing the heart of the Mississippi Delta—a cultural heritage destination for tourists including history buffs, blues enthusiasts, and eco-tourists. Nearby cultural heritage sites including Mont Helena, historic burial mounds, the Delta National Forest, and annual events like the Great Delta Bear Affair draw visitors into the area. Significant area historic sites like Vicksburg's military park to the south, and the B.B. King Museum or Grammy Museum to the north, draw tourists traveling along the Blues Highway. Nearby wildlife management areas, like the Sunflower Wildlife Management Area, draw sports tourists into the area to fish, boat, and to hunt waterfowl and deer.
- Disaster Recovery and Construction: The March 2023 EF-4 tornado devastated Rolling Fork, destroying 80-85% of homes and causing over $80 billion in national weather-related damages. Recovery efforts, including rebuilding homes and infrastructure, continue into 2025, generating demand from construction workers, contractors, recovery staff, and displaced residents.
- Challenges include a shrinking population, low overall tourism volume in rural Mississippi, and economic vulnerabilities. Local economic growth is stagnant. Unemployment and poverty rates are higher than state averages, limiting local consumer spending but creating opportunities for budget-oriented developments. Market Demand Drivers for an economy extended-stay hotel (focused on weekly/monthly stays with kitchenettes and basic amenities) would likely come from transient workers and niche tourists rather than high-volume leisure travel.

Rolling Fork's market shows mixed potential. The population is declining, median income is low, and the area has high poverty rates. Demand drivers include healthcare employment, agricultural seasonal workers, and limited tourism from heritage and cultural events. Post-tornado recovery may temporarily boost short-term stays. Overall, Mississippi Delta hotel occupancy is lower than state averages (e.g. 63% statewide as compared to an estimated 50 to 60% occupancy in the rural Delta areas. Extended-stay demand is strong nationally, with 72 % occupancy and $118 Average Daily Rate (ADR); in rural Sharkey County these estimates shrink to between $70 to $90 ADR.

The cultural heritage and eco-tourism potential for Sharkey County is contained in a separate study conducted by the Stennis Institute of Government

Operating Expenditure Estimates

Assuming operating expense of $10,000 per room annually with a 2% annual increase, the annual operating expense in year one is projected to be $300,000 initially. Operating expenditure breakdown include labor (50 to 60% of total, or $150,000 to $180,000 annually, utilities (estimated at $50,000), maintenance at $30,000, insurance and taxes at $35,000, and supplies and marketing estimated at $30,000 annually. Extended-stay hotels benefit from lower housekeeping costs due to fewer turnovers.

Cash Flow Statement for Extended-Stay Hotel

This pro forma uses the specified parameters: 30 rooms, 10,950 annual room nights, occupancy ramping from 40% in Year 1 to 50% in Year 2 and 60% stabilized from Year 3 onward (a common linear ramp for hotel projections). ADR starts at $80 with 3% annual growth, annual operating expense estimated at $300,000 initially ($10,000 per room) with 2% annual escalation (standard for inflation adjustments in hotel models). Total project cost is $4.95 million, with 70% debt ($3.465 million) at 6% over 20 years, yielding fixed annual debt service of $297,892 calculated via the amortizing loan formula. Note that current 2025 hotel loan rates are higher (around 7.25%), so 6% implies favorable terms, possibly through programs like USDA B&I loans.

Table 18: Estimated 5-Year Cash Flow Statement for Free-Standing 30-Room Extended Stay Hotel with No Subsidies

Year	Occupancy (%)	ADR	Revenue	Operating Expenses	Net Operating Income	Debt Service	Cash Flow
1	40	$80.00	$350,400	$300,000	$50,400	$297,892	**-$247,492**
2	50	$82.40	$451,140	$306,000	$145,140	$297,892	**-$152,752**
3	60	$84.87	$557,596	$312,120	$245,476	$297,892	**-$52,416**
4	60	$87.42	$574,349	$318,362	$255,987	$297,892	**-$41,905**
5	60	$90.04	$591,563	$324,730	$266,833	$297,892	**-$31,059**
6	60	$92.74	$609,302	$331,224	$278,078	$297,892	**-$19,814**
7	60	$95.52	$627,566	$337,849	$289,717	$297,892	**-$8,175**
8	60	$98.39	$646,422	$344,606	$301,816	$297,892	$3,924
9	60	$101.34	$665,804	$351,498	$314,306	$297,892	$16,414
10	60	$104.38	$685,777	$358,528	$327,249	$297,892	$29,357

https://grok.com/share/c2hhcmQtNA%3D%3D_3d18c91a-768a-4597-8a03-11ea417ceca9

By including the extended stay hotel as an element of the Hospital Medical Retail Complex, loan amounts might be reduced by funding from the following sources:

- CDBG-DR FUNDING
- GOVERNOR REEVES MISSISSIPPI RURAL HEALTH TRANSFORMATION PROGRAM PLAN
- EDA-DISASTER-2025 FY DISASTER SUPPLEMENTAL DEPARTMENT OF COMMERCE
  See: HTTPS://GRANTS.GOV/SEARCH-RESULTS-DETAIL/359225

Potential Telehealth Integration Strategies for Sharkey-Issaquena Community Hospital

Integrating telehealth into a 29-bed Critical Access Hospital in rural Sharkey County, Mississippi addresses key challenges such as limited access to specialty care, physician shortages — Mississippi Ranks worst nationally at 180.8 physicians per 100,000 residents — and high rates of chronic diseases like diabetes and heart disease in this medically underserved area.

- Telehealth can reduce patient transfers to distant facilities (e.g., Vicksburg or Greenville, 40+ miles away), lower costs, and improve outcomes by enabling virtual consultations, remote monitoring, and preventive care. As a Critical Access Hospital, Sharkey-Issaquena Community Hospital qualifies for cost-based Medicare reimbursement at 101% for telehealth services, with temporary flexibilities allowing services without geographic restrictions through December 31, 2024 (potentially extendable).
- In Mississippi, where 53.2% of residents live in rural areas and telehealth is part of the state's $500 million Rural Health Transformation Program (RHTP), integration aligns with initiatives to expand virtual care access and innovative payment models.
- Benefits include increased outpatient revenue (potentially boosting net patient revenue by 5-10% through e-visits) and reduced uncompensated care by keeping services local.

Planning Phase

- Begin with a thorough assessment and strategic roadmap to ensure sustainability.
- Community and Needs Assessment: Survey residents on internet access (critical in rural areas with spotty broadband), medical needs (e.g., specialty shortages in cardiology or infectious diseases), and telehealth receptiveness. Use local reports, Census data, or informal polls via phone, online, or community events.
- In Sharkey County, with 27.3-35.1% poverty and 25.2% over age 60, prioritize services for chronic disease management and elderly care.

Service Selection and Business Planning:

- Focus on high-impact services like virtual primary care, e-consults for specialists, remote patient monitoring (RPM) for conditions like diabetes, and emergency telehealth (e.g., TelEmergency model).
- Develop a business plan outlining ROI, with telehealth potentially reducing healthcare resource utilization and spending for Medicare patients.

Technology and Infrastructure Evaluation:

- Ensure reliable broadband, devices (laptops, tablets, smartphones), and software for electronic health records (EHR) integration, patient portals, and RPM data.
- Use mobile hotspots for connectivity gaps.
- Comply with CMS requirements for secure platforms and no location restrictions for patients through 2024.

Staffing and Credentialing:

- Reorganize roles for 120 FTEs, adding telehealth coordinators or training existing nurses ($64,532 avg salary) and physicians.
- Use CMS telemedicine credentialing rules, allowing CAHs to rely on distant-site hospital privileging without on-call list mandates for telehealth providers.

Implementation Phase:

- Execute with a focus on collaboration, training, and workflow optimization.
- Infrastructure Development and Partnerships: Invest in secure platforms for real-time consultations. Partner with entities like the University of Mississippi Medical Center (UMMC) for TelEmergency (proven to save rural CAHs through emergency telehealth), Equum Medical for virtual workforce strategies, or infectious disease specialists for co-management.
- Training and Workflow Integration: Train staff on protocols, clinical workflows, and tools like antibiotic stewardship via telehealth.
- Implement efficient processes: front-desk for scheduling, tech support for troubleshooting, and billing for reimbursements. Start with pilot services (e.g., audio-video visits; note Mississippi Medicaid excludes audio-only for physical health).
- Marketing and Community Outreach: Promote via signage, brochures, social media, radio ads, and health fairs to address misconceptions and build trust. Target low-income and elderly residents, emphasizing convenience to retain local revenue and reduce transfers.
- Reimbursement and Compliance: Bill Medicare at 80% of Physician Fee Schedule (PFS) for distant-site services under CAH optional method (101% costs). Include telehealth in network agreements for transfers. Track uncompensated care (5.53% median) and pursue DSH payments. Adhere to CMS flexibilities for home visits (non-behavioral through 9/30/25) and audio-only for mental health.
- Sustainability and Evaluation: Monitor and adapt for long-term viability.
- Performance Metrics and Feedback: Track ROI through profits/losses, appointment trends, patient outcomes, and new patient acquisition. Collect feedback via surveys on quality, cost, and access; adjust based on results.
- Ongoing Partnerships and Funding: Sustain through RHTP funding, collaborations with UMMC, and grants. Position telehealth as a growth tool, learning from TelEmergency's emphasis on stakeholder engagement and legislative support to navigate reimbursement and expansion.
- Risk Mitigation: Address barriers like broadband limitations with backups and policy advocacy. Aim for break-even integration within 2-3 years, contributing to overall hospital margins.

Estimate startup costs at $100,000-$200,000 for software, devices, and training, offset by grants from HRSA, SHIP ($616K statewide in 2022), or Mississippi's RHTP.

These strategies position Sharkey-Issaquena Community Hospital as a telehealth leader in rural Mississippi, enhancing care access and financial stability. Consult MSDH and CMS for tailored guidance.

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