

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Sarah D. Culbertson Memorial Hospital		
Street Address:	238 S. Congress Street		
City and Zip Code:	Rushville, IL 62681		
County:	Schuyler	Health Service Area: 3	Health Planning Area: E-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital
Street Address:	238 S. Congress Street
City and Zip Code:	Rushville, IL 62681
Name of Registered Agent:	Gregg Snyder
Registered Agent Street Address:	238 S. Congress Street
Registered Agent City and Zip Code:	Rushville, Illinois 62681
Name of Chief Executive Officer:	Gregg Snyder
CEO Street Address:	238 S. Congress Street
CEO City and Zip Code:	Rushville, Illinois 62681
CEO Telephone Number:	217-322-4321

Type of Ownership of Applicants

- | | |
|--|--|
| ☐ Non-profit Corporation | ☐ Partnership |
| ☐ For-profit Corporation | ☒ Governmental |
| ☐ Limited Liability Company | ☐ Sole Proprietorship |
| ☐ Other | |
- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
 - Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Joe Ourth
Title:	Partner
Company Name:	Saul Ewing LLP
Address:	161 N. Clark, Suite 4200, Chicago, IL 60601
Telephone Number:	312-876-7815
E-mail Address:	joe.ourth@saul.com
Fax Number:	

Additional Contact [Person who is also authorized to discuss the application for permit]

Name:	
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence after permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name:	Gregg Snyder
Title:	CEO
Company Name:	Sarah D. Culbertson Memorial Hospital
Address:	238 S. Congress Street, Rushville, Illinois 62681
Telephone Number:	217-322-4321
E-mail Address:	gsnyder@sdcmh.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital
Address of Site Owner: 238 Congress Street, Rushville, Illinois 62681
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital	
Address: 238 Congress Street, Rushville, Illinois 62681	
☐ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☒ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship ☐ Other
- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

- ☐ Substantive
- ☒ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital (“SDCMH”) is a 22-bed critical access hospital located in Rushville Illinois and has been serving patients since 1921. Rushville is a community of approximately 3,000 residents over 56 miles west of Springfield.

The original hospital building was constructed over 100 years ago (with subsequent additions). SDCMH completed a Master Facility Plan that outlined an extensive list of needed improvements, more than could be feasibly undertaken at one time. After careful review, it prioritized three elements that comprise the improvements in this project.

The project has three primary components, including (i) replacing aging mechanical equipment, and (ii) constructing a 12,645 square-foot addition to consist of two operating rooms to replace the current one operating room and one procedure room, new laboratory, and main entry, and (iii) renovation of the emergency department (the “Project”). The original 1921 structure will be demolished to create space for the surgery department addition. The Project also includes renovations for Imaging, Emergency, Pharmacy and Administration, and also includes adding fire suppression sprinklers and removal of asbestos.

The Project creates no new categories of service and adds no beds and is classified as “non-substantive” under the Review Board’s regulations.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$159,712	\$136,051	\$295,763
Site Survey and Soil Investigation	\$19,386	\$16,514	\$35,900
Site Preparation	\$492,912	\$419,888	\$912,800
Off Site Work	0	0	0
New Construction Contracts	\$4,351,121	\$3,706,510	\$8,057,631
Modernization Contracts	\$5,228,186	\$4,453,640	\$9,681,825
Contingencies	\$749,239	\$638,241	\$1,387,480
Architectural/Engineering Fees	\$882,225	\$751,525	\$1,633,750
Consulting and Other Fees	\$251,345	\$214,109	\$465,454
Movable or Other Equipment (not in construction contracts)	\$1,751,212	\$53,187	\$1,804,399
Bond Issuance Expense (project related)	0	0	0
Net Interest Expense During Construction (project related)	\$170,100	\$144,900	\$315,000
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized	\$1,052,960	\$817,744	\$1,870,704
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	\$15,108,398	\$11,352,308	\$26,460,706
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			\$20,000,000
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			\$6,460,706
TOTAL SOURCES OF FUNDS			\$26,460,706
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project	☐ Yes	☒ No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service ☐ Yes ☒ No		
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ <u>N/A</u> .		

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☐ Preliminary ☒ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): <u>April 30, 2029</u>
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies ☒ Financial Commitment will occur after permit issuance.
APPEND DOCUMENTATION AS <u>ATTACHMENT 8</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable? ☐ Cancer Registry ☒ APORS ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ☒ All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.
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Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Not Reviewable Space [i.e., non-clinical]: means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers. [20 ILCS 3960/3]

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Emergency Dept	\$2,380,386	2061	2891	0	2891		
Surgery	\$5,255,194	3673	4842	4842	0		3673
Radiology	\$2,699,240	2841	3620	0	3620		
Pharmacy	\$656,307	863	832	0	832		31
Lab	\$1,375,940	962	1414	1414	0		962
Post Anesthesia Recovery	\$2,741,331	1298	2760	2760	0		1298
Total Clinical	\$15,108,398	11,698	16,359	9,016	7,343		5,964
NON-REVIEWABLE							
Public/Waiting/Chapel	\$2,517,855	2144	2852	1137	1715		
Administrative	\$2,678,239	2934	3450	0	3450		
Staff support / Holding	\$1,925,718	1960	2272	1023	1249		
Loading Dock / Canopies	\$534,395	900	450	450	0		450
Mechanical / Basement	\$2,629,073	18,288	16,756	1500	2096	13,160	1532
Stairs / Elevator	\$467,706	467	740	442	0	298	
Information Tech. / Elec.	\$599,322	397	808	0	808		
Total Non-clinical	\$11,352,308	27,090	27,328	4,552	9318	13,458	1982
TOTAL	\$26,460,706	38,788	43,687	13,568	16,661	13,458	7,946

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available**. Include observation days in the patient day totals for each bed service. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Sarah D Culbertson Memorial Hospital			CITY: Rushville		
REPORTING PERIOD DATES: From: January 1, 2024 to: December 31, 2024					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	22	106	534	0	22
Obstetrics	0	0	0	0	0
Pediatrics	0	0	0	0	0
Intensive Care	0	0	0	0	0
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long-Term Care	0	0	0	0	0
Specialized Long-Term Care	0	0	0	0	0
Long Term Acute Care *	*			0	0
Other ((identify))	0	0	0	0	0
TOTALS:	22	106	534	0	22

* LTC Swing

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist).
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital *

in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

GREGG SNYDER
PRINTED NAME

EXECUTIVE DIRECTOR
PRINTED TITLE

Notarization:

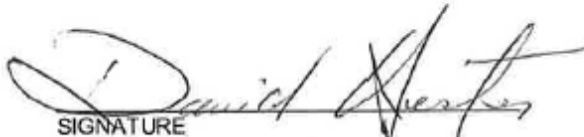
Subscribed and sworn to before me
this 26 day of February 2026


Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

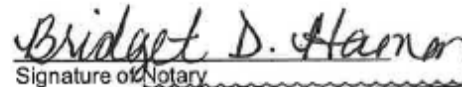

SIGNATURE

DAVID HESTER
PRINTED NAME

Vice-Chairman
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 26 day of February 2026


Signature of Notary

Seal



SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
 - a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
 - b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.
 - c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
 - d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
 - e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost.
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes.
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality, and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions, or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.
3. Evidence that the shell space is being constructed due to:
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data is available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

M. Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ Surgery – OR	1	2
☐ Surgery – Procedure	1	0
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
1APPEND DOCUMENTATION AS <u>ATTACHMENT 31</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [**Indicate the dollar amount to be provided from the following sources**]:

\$6,460,706	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.
\$20,000,000	d)	Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc. 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment. 5) For any option to lease, a copy of the option, including all terms and conditions.

_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent.
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
\$26,460,706	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS <u>ATTACHMENT 34</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding, or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All the project's capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available.
- 2) That the selected form of debt financing will not be at the lowest net cost available but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors.
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for **ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES** [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, **including the impact on racial and health care disparities in the community**, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 37.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year
Inpatient			

	Outpatient				
	Total				

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS **ATTACHMENT 39**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: _____
(Name) (Address)

(City) (State) (ZIP Code) (Telephone Number)
2. Project Location: _____
(Address) (City) (State)

(County) (Township) (Section)
3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (<https://msc.fema.gov/portal/home>) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the **Go to NFHL Viewer** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No ___?

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN?

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: _____ Effective Date: _____

Name of Official: _____ Title: _____

Business/Agency: _____ Address: _____

(City) (State) (ZIP Code) (Telephone Number)

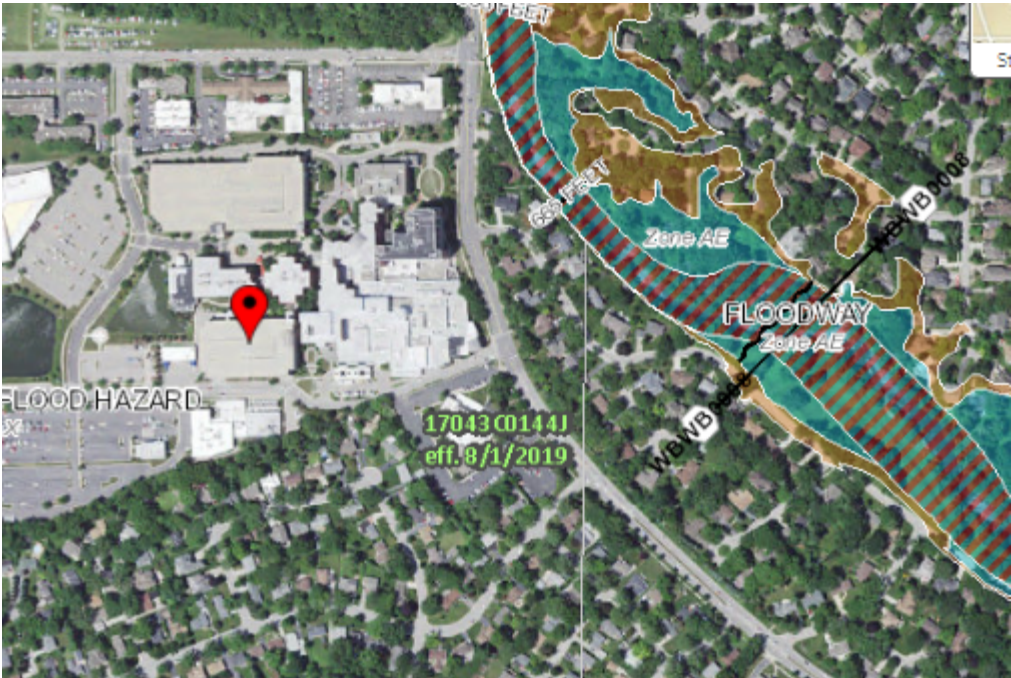
Signature: _____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

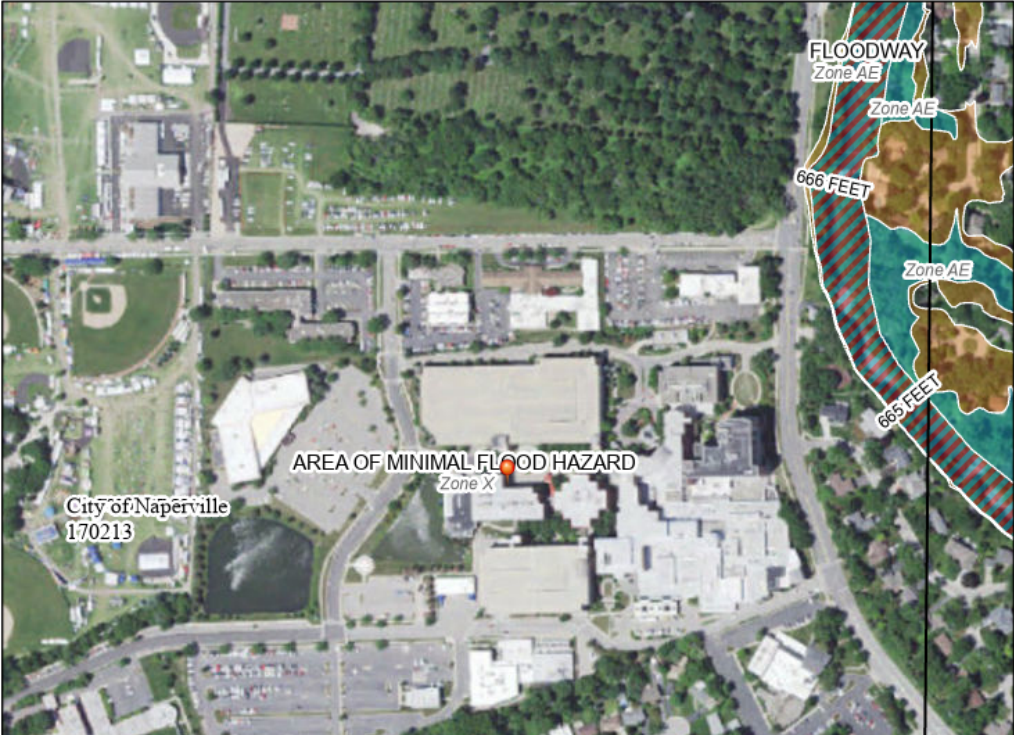
Floodplain Map Example

The image below is an example of the floodplain mapping required as part of the IDPH swimming facility construction permit showing that the swimming pool, to undergo a major alteration, is outside the mapped floodplain.



National Flood Hazard Layer FIRMette

88°9'26"W 41°45'53"N



Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS	Without Base Flood Elevation (BFE) Zone A, V, A99
	With BFE or Depth Zone AE, AO, AH, VE, AR Regulatory Floodway
OTHER AREAS OF FLOOD HAZARD	0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X
	Future Conditions 1% Annual Chance Flood Hazard Zone X
	Area with Reduced Flood Risk due to Levee. See Notes, Zone X
	Area with Flood Risk due to Levee Zone D
OTHER AREAS	NO SCREEN Area of Minimal Flood Hazard Zone X
	Effective LOMRs
GENERAL STRUCTURES	Channel, Culvert, or Storm Sewer
	Levee, Dike, or Floodwall
OTHER FEATURES	Cross Sections with 1% Annual Chance Water Surface Elevation
	Coastal Transect
	Base Flood Elevation Line (BFE)
	Limit of Study
	Jurisdiction Boundary
MAP PANELS	Digital Data Available
	No Digital Data Available
	Unmapped

The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS			
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2	Site Ownership		36-39
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		40
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		41-42
5	Flood Plain Requirements		43-44
6	Historic Preservation Act Requirements		45-50
7	Project and Sources of Funds Itemization		51-67
8	Financial Commitment Document if required		
9	Cost Space Requirements		68
10	Discontinuation		
11	Background of the Applicant		69
12	Purpose of the Project		70-108
13	Alternatives to the Project		109-112
14	Size of the Project		114-118
15	Project Service Utilization		119-122
16	Unfinished or Shell Space		N/A
17	Assurances for Unfinished/Shell Space		N/A
	Service Specific:		
18	Medical Surgical Pediatrics, Obstetrics, ICU		N/A
19	Comprehensive Physical Rehabilitation		N/A
20	Acute Mental Illness		N/A
21	Open Heart Surgery		N/A
22	Cardiac Catheterization		N/A
23	In-Center Hemodialysis		N/A
24	Non-Hospital Based Ambulatory Surgery		N/A
25	Selected Organ Transplantation		N/A
26	Kidney Transplantation		N/A
27	Subacute Care Hospital Model		N/A
28	Community-Based Residential Rehabilitation Center		N/A
29	Long Term Acute Care Hospital		N/A
31	Clinical Service Areas Other than Categories of Service		123-144
31	Freestanding Emergency Center Medical Services		123-144
32	Birth Center		N/A
	Financial and Economic Feasibility:		
33	Availability of Funds		N/A
34	Financial Waiver		145 & Appendix
35	Financial Viability		146-148
36	Economic Feasibility		149
37	Safety Net Impact Statement		150-159
38	Charity Care Information		160
39	Flood Plain Information		161

Section I. Type of Ownership of Applicant/Co-Applicant

Attachment 1

Schuyler County District Hospital d/b/a Sarah D. Culbertson Memorial Hospital (“SDCMH”) is a Hospital District organized under ILCS 70/910-15. See attached documentation.

STATE OF ILLINOIS }
COUNTY OF SCHUYLER } ss.

IN THE COUNTY COURT OF SCHUYLER
COUNTY, ILLINOIS.

NO. 1176.

IN THE MATTER OF THE ESTABLISH-
MENT OF A HOSPITAL AUTHORITY. }

ORDER ESTABLISHING HOSPITAL
AUTHORITY AND APPOINTING
COMMISSIONERS THEREFOR.

ORDER.

AND now on this 2nd day of January, A. D., 1948, that being one of the regular judicial days of the County Court of Schuyler County, Illinois, regularly organized and convened, this cause having come on for further hearing upon the petition heretofore filed herein, and the proceedings heretofore had in this cause; and the Court having examined said petition, and all the proceedings had herein, and having considered the same, and being now fully advised in the premises, upon consideration thereof, FINDS:

I.
THAT on the 6th day of October, A. D., 1947, there was filed in the office of the County Clerk of Schuyler County, Illinois, with the County Clerk of said County, and received by said County Clerk, and by him made a part of the official records of his said office, a Petition;

THAT said Petition contains and sets forth a description of an area of compact and contiguous territory having a population of more than Five Thousand (5000) inhabitants, and containing more than one municipality as defined by an act entitled "A Bill for an Act in Relation to Hospital Authorities", enacted by the 65th General Assembly of the State of Illinois, in the year 1947, and in which there was not at the time said petition was filed, and is not now any territory contained within the corporate limits of an existing Hospital Authority;

THAT said Petition is signed by more than five hundred (500) electors residing within the area of compact and contiguous territory described therein, is addressed to the Judge of the County Court of said Schuyler County, sets forth a description of the territory thereby sought to be, and intended to be embraced in the proposed Hospital Authority, sets forth the names of the municipalities located within said area of compact and

-1-

contiguous territory, contains and sets forth the name of the proposed authority, and sets forth a request that the question be submitted to the electors residing within the limits of such proposed authority whether they will incorporate as an authority under an Act entitled "An Act in Relation to Hospital Authorities", known as S. B. 221, approved July 23, 1947, for the purpose of constructing and maintaining a general hospital, the approximate location of which shall be in the City of Rushville, County of Schuyler in the State of Illinois.

II.

THE COURT FURTHER FINDS that the petitioners, whose names and signatures appear upon said petition so filed as aforesaid, have by their said petition authorized and designated Paul B. Willard, Frederick D. Culbertson, Guy H. Miller and Edwin A. Dyson, all residents of, and electors within said area of compact and contiguous territory intended to be embraced in said proposed Authority, to appear for and represent them on said petition, and in the proceedings thereon in said County Court, with authority to amend, to move to dismiss or to withdraw said Petition.

AND FURTHER FINDS that upon the filing of said petition with said County Clerk, he, the said County Clerk did on the 6th day of October, A. D., 1947, present the same to the Judge of the County Court of said Schuyler County, Illinois, and that upon presentation of said petition to him, he, the said Judge of said County Court did, by his order duly entered thereon, set said Petition for hearing on the 10th day of November, A. D., 1947, at the hour of 10:00 o'clock, A. M. of said day, in the County Court room in the Court House, at Rushville, Schuyler County, Illinois, that being a date not less than thirty (30) nor more than forty (40) days after said Petition had been filed with the County Clerk of said County, as aforesaid.

III.

AND THE COURT FURTHER FINDS that pursuant to an Order of this Court heretofore entered herein, Notice was given by the County Judge of Schuyler County, Illinois, of the time when, and place where such hearing would be held upon said Petition; that said notice was given by publication in The Rushville Times, a weekly secular newspaper having a general circulation within the territory proposed to be incorporated as a Hospital Authority,

on three separate days, the first such notice having been given in an issue of said newspaper dated the 9th day of October, A. D., 1947, and the last publication thereof having been made in the issue of said paper published on the 23rd day of October, A. D., 1947, the first publication thereof having been made not less than twenty days prior to the date set for such hearing;

AND FURTHER FINDS that the filing fee on said Petition and the costs of printing and publication of such notices of public hearing thereon, have been paid in advance by said Petitioners.

IV.

AND THE COURT FURTHER FINDS that pursuant to said notice of hearing upon said petition, a hearing has been had and held thereon at the time and in the place specified in said notice of hearing, and in the manner provided by law; that no continuances of said hearing were had; that no amendments to said petition have been made and no motion or motions have been made by petitioners or their representatives to amend or dismiss or withdraw their said petition; and that upon completion of such hearing upon said petition as aforesaid, the County Judge of Schuyler County, Illinois, by written order entered in this cause on the 10th day of November, A. D., 1947, did find and determine that the territory described in said petition and intended to be embraced within said Hospital Authority meets the requirements of the Act under which said proceedings are brought, by which said Order said County Judge did also find and determine that the Petition so filed as aforesaid, is sufficient, and did find that the proceedings had thereon were regular and in the manner prescribed by law; that said petition bears the genuine signature of more than five hundred electors, legally residing within the area proposed to be incorporated as such Hospital Authority.

V.

AND THE COURT FURTHER FINDS that according to the last federal census taken in the year 1940, the population of the City of Rushville is 2480; that the population of the Village of Browning is 450; that the population of the Village of Littleton is 260; and that the population of the Village of Camden is 200; that all of said municipalities are located wholly within said territory; and further finds that no Petition has been filed by any

number of the regular legal voters residing within that portion of said proposed territory lying outside the corporate limits of any municipality located within said proposed area, requesting a separate vote upon said proposition in such unincorporated area, and that no such Petition has been presented to the County Judge of said County of Schuyler, State of Illinois, at the time of the public hearing held upon the Petition so filed herein as aforesaid; and further finds that only one petition has been filed in this proceeding, and that that petition was the petition filed with the County Clerk of this County on the 6th day of October, A. D., 1947, as hereinbefore found.

VI.

AND THE COURT FURTHER FINDS that by said written Order so entered of record by the County Judge of said County, on the 10th day of November, A.D., 1947, as aforesaid, it was ordered, adjudged and decreed among other things, that an election be held within the territory intended to be embraced in said proposed Hospital Authority as prayed in said Petition, and that said election was by the terms of said Order, called for the 13th day of January, A. D., 1948, between the hours of six o'clock, A.M. and Five o'clock P.M. of said day, that date being not less than thirty (30), nor more than Ninety (90) days after the date of entry of said order;

AND THAT by said Order so entered of record as aforesaid, notice of such election was ordered to be given by publication on three separate days, in a weekly newspaper having a general circulation within said territory, the first such publication to be given not less than thirty (30) days prior to the date of said election, and by posting notices in ten (10) of the most public places in said territory;

AND THE Court further finds that thereafter, pursuant to said Order, notice of such election on the question of establishing Schuyler County Hospital Authority was published in The Rushville Times, a weekly secular newspaper having a general circulation within said territory, three separate days, for three successive weeks, the first publication thereof having been made in the issue of said newspaper on the 27th day of November, A. D., 1947, and the last publication thereof having been made in the issue of said newspaper published on the 11th day of December, A. D., 1947; and that on the 3rd day of December, A. D., 1947, written notices of said election were

posted in ten (10) of the most public places in said territory as is by law required, and that said notices so published as aforesaid, and that each of said notices so posted as aforesaid, gave notice that a special election would be held on Tuesday, the 13th day of January, A. D., 1948, within the territory to be embraced in such Hospital Authority, to-wit: The County of Schuyler, situated in the State of Illinois, at which election there would be submitted to the electors legally residing within the above described territory, the following proposition: Shall "An Act in Relation to Hospital Authorities", effective the 23rd day of July, 1947, be adopted, and the Schuyler County Hospital Authority be established; that each of said notices further gave notice that such authority, upon its establishment, would have the powers, objects and purposes provided by said Act, including the power to levy a tax of not to exceed .075 Per Cent of the full fair cash value of taxable property, included within the territorial limits of such authority, as equalized or assessed by the Department of Revenue for Hospital operation and maintenance and for other corporate purposes, and the power to issue tax secured bonds in the manner provided in said Act; and gave notice that each legal voter residing within said territory should have the right to cast a ballot at such election; that the polls at each and all polling places will be open at 6:00 o'clock, A. M., and close at 5:00 o'clock, P. M. on said Tuesday, the 13th day of January, A. D., 1948; and gave notice that the precincts and polling places for said election had been established and designated by the Judge of Schuyler County, Illinois, pursuant to law, and set forth the precinct number, the boundary of each such precinct, and the polling place in each such precinct so designated and established, such precincts being ten (10) in all, which notice was dated the 10th day of November, A. D., 1947;

AND THE COURT FURTHER FINDS that the form of the ballot used and voted at said election was in the form prescribed by law; that a specimen of such ballot was published in the Rushville Times, a weekly secular newspaper having general circulation within said territory proposed to be established as a hospital authority, prior to the holding of said election;

AND FURTHER FINDS that by said Order so entered on the 10th day of November, A. D., 1947, as aforesaid, ten election precincts were created, designated and established within said territory, and ten polling places

designated and established for the holding of such election; that the number and boundaries of such election precincts and the locations of such polling places were established, designated and set forth in said order, and that by the terms of said order, said County Judge did appoint, designate and name the Judges and Clerks of said election, and did designate and order that the ballot to be voted on at said election should be in the manner prescribed by law, and did direct that said ballots, for all of said precincts, be prepared under the direction of the Clerk of the County Court of Schuyler County, Illinois, and that the facsimile signature of the County Clerk of Schuyler County, Illinois, be affixed on the back of each such official ballot, and that said Clerk arrange for the publication and printing of said ballots, in accordance with the Statute in such case made and provided, and that the election returns from such election be filed with said Clerk.

VII.

AND THE COURT FURTHER FINDS that none of the municipalities lying and being within the said proposed territory petition for a special vote to be had on the proposition, and that in consequence thereof the precincts and polling places were indicated in such a way as to afford all of the legal voters in all of the territory a convenient place in which to cast their vote.

VIII.

AND FURTHER FINDS that pursuant to said order and said notices of election, an election was had and held within said territory at and in the respective precincts and polling places so designated, on the 13th day of January, A. D., 1948, upon the proposition of whether "An Act in Relation to Hospital Authorities", effective the 23rd day of July, A. D., 1947, be adopted and the Schuyler County Hospital Authority be established; that said election was conducted and said proposition was submitted within said territory under, and in accordance with the provisions of Section 28-3 of the Election Code of the State of Illinois, and the provisions of the Election Code of the State of Illinois, and the provisions of the Election Code applicable to the conducting of general elections within said territory, except as is by the provisions of said "Act in Relation to Hospital Authorities", otherwise provided, and as to that extent, was conducted and submitted in accordance with the provisions and requirements of said Hospital Authorities Act.

IX.

AND THE COURT FURTHER FINDS that at the close of said election and the delivery of the returns of such election, the County Judge of said Schuyler County, did canvass such returns within two days from the date on which said election was held, and determine the result of said election within said territory, and does now hereby determine and declare the result of said election to be that a majority of the votes cast at said election upon the question of the adoption of said Act in Relation to Hospital Authorities, as set forth in the ballots cast at said election, and the establishment of a Hospital Authority to be known as Schuyler County Hospital Authority, in the territory described in said petition and herein described as "The County of Schuyler in the State of Illinois", were cast in favor of said proposition and the establishment of such Hospital Authority; that a total of Twenty-four Hundred Forty (2440) ballots were cast at said election on said date of January 13th, 1948; that of said total vote cast, Twenty-two Hundred Sixty (2260) of such ballots were marked "Yes" and Ninety-eight (98) of such ballots were marked "No", and that Eighty-two (82) of such ballots so cast were defective and spoiled ballots.

THE COURT THEREFORE FINDS and determines and declares that a majority of the votes cast at said election upon said question were cast in favor of the same, and that the inhabitants of said territory so described in said petition and herein described have accepted the provisions of said "Act in Relation to Hospital Authorities", and that said territory, described as "The County of Schuyler in the State of Illinois", has by virtue thereof been, and is hereby declared to be an Organized Hospital Authority under and by virtue of the provisions of the Statutes of the State of Illinois, in such case made and provided, under the name of "Schuyler County Hospital Authority", to include the entire area of compact and contiguous territory constituting said County of Schuyler in the State of Illinois.

AND THE COURT FURTHER FINDS and hereby declares that there are no municipalities within the area of said Schuyler County which have a population of Five Thousand (5000) or more inhabitants; that the territory comprising said Schuyler County Hospital Authority lies wholly within the said County of Schuyler in the State of Illinois; and that no petition has been filed in these proceedings requesting a separate vote upon said question to be taken in said territory outside the corporate limits of any municipality or municipalities within said territory.

AND THE COURT FURTHER FINDS that all proceedings had herein, including the filing of the Petition with the County Clerk of said Schuyler County, Illinois, the presentation of the same by said Clerk to the Judge of the County Court of said County, the setting of said petition for hearing, within not less than thirty (30) days, nor more than Forty (40) days after the filing thereof, the notice given by such Judge of the time and place where such hearing would be held, and the publication thereof, the payment of the filing fees on said petition and the costs of printing and publication or posting of notices of such public hearing upon said petition, the hearing upon said petition and the order entered thereon, the notices of election and the publication thereof not less than thirty (30) days prior to the date of such election, and the posting of notices thereof, and the contents of such notices, and the form of ballot to be used at such election, and the publication of specimen of said ballot in a newspaper having general circulation within said territory, the holding of said election and the canvass of the return thereof, and the determination and declaration of such results of said election, have been duly and regularly had and held in accordance with the Statute in relation to Hospital Authorities; and that said territory described as Schuyler County Hospital Authority should henceforth be deemed an organized Hospital Authority under said Act by the name and style of "Schuyler County Hospital Authority."

IT IS THEREFORE ORDERED, ADJUDGED and DECREED by the Court that all such proceedings had and held herein be and they are hereby approved and confirmed by the Order of this Court and said area of compact and contiguous territory comprising the County of Schuyler in the State of Illinois, is hereby declared to constitute the Schuyler County Hospital Authority.

AND IT IS FURTHER ORDERED by the Court that the following named persons, each of whom resides within the territory hereby established as the Schuyler County Hospital Authority, be and they are hereby appointed by this Court as the Commissioners of and for said Schuyler County Hospital Authority, to-wit:

Guy E. Miller, Lewis W. Barco,
Leslie Galt, Delia Walton, and
William Eifert.

DATED at Bushville, Illinois, this 2nd day of February, A. D., 1948.

CERTIFICATE

I, Jacqueline M. Rehman, Clerk of the Circuit Court of Eighth Judicial Circuit of Illinois, Schuyler County, do hereby certify that this is a true and complete copy of the original instrument filed and retained in this office.

Witness

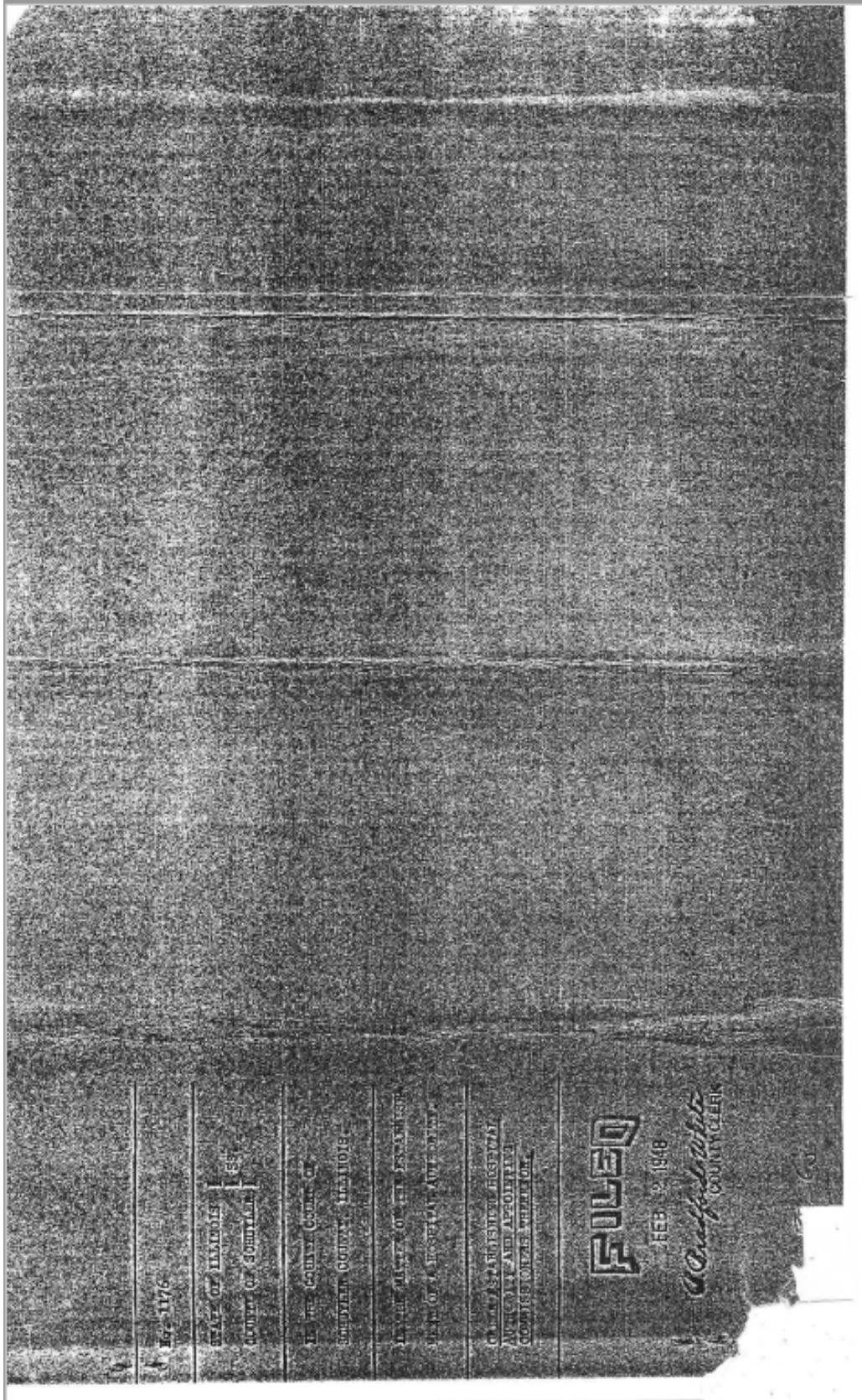
Jan 13 1948

Jacqueline M. Rehman
Clerk of the Circuit Court

SEAL BY

Deputy

Frank W. Byrnes
JUDGE.



Section I. Site Ownership

Attachment 2

Attached is information from the Schuyler County Assessor's office evidencing that Sarah D. Culbertson owns the real estate at the location of the project.

Property Information		
Parcel Number 08-30-356-012	Site Address 238 S CONGRESS ST RUSHVILLE, IL 62681 HOSPITAL	Owner Name & Address SARAH D CULBERTSON MEMORIAL HOSPITAL SCHUYLER CO HOSPITAL DIST 238 S CONGRESS RUSHVILLE, IL 62681
Tax Year 2024 (Payable 2025) ☐		
Sale Status None	Neighborhood Code RUSHVILLE CITY	Land Use
Property Class 0090 - Tax Exempt	Tax Code 12001 -	Tax Status Exempt
Net Taxable Value 0	Tax Rate 0.000000	Total Tax \$0.00
Township RUSHVILLE	Acres 0.0000	Mailing Address SARAH D CULBERTSON MEMORIAL HOSPITAL SCHUYLER CO HOSPITAL DIST 238 S CONGRESS RUSHVILLE, IL 62681
Tract Number 1211200630	Lot Size 105' X 215'	TIF Base Value 0
Legal Description LOTS 11 & 12 BLK 13 ORIGINAL PLAT DOCKET #87-85-117 (MAIN HOSPITAL)		

Property Map

View Full Screen

Schuyler County

Find a Parcel by Owner, Address, or Parcel ID

Results

Parcel

Parcel Information

Parcel Number (Unformatted)

0830356012

Acreage

0

Parcel Number

08-30-356-012

Alternate Parcel Number

12-112-006-30

Township

12

Township Name

RUSHVILLE

Site City, State, ZIP Code

RUSHVILLE IL 62681

Gross Acres

0

Homesite Acres

0

Farm Acreage

0

Class

90

Lot Dimension

105' X 215'

Document NO.1

Owner 1

SARAH D CULBERTSON MEMORIAL HOSPITAL

Owner Names

Name	Tax Bill	Address
SARAH D CULBERTSON MEMORIAL HOSPITAL	Y	SCHUYLER CO HOSPITAL DIST 238 S CONGRESS RUSHVILLE, IL 62681

No Billing Information

Assessments							
Level	Homesite	Dwelling	Farm Land	Farm Building	Mineral	Total	Partial Building
DOR Equalized	0	0	0	0	0	0	No
Department of Revenue	0	0	0	0	0	0	No
Board of Review Equalized	0	0	0	0	0	0	No
Board of Review	0	0	0	0	0	0	No
S of A Equalized	0	0	0	0	0	0	No
Supervisor of Assessments	0	0	0	0	0	0	No
Township Assessor	0	0	0	0	0	0	No
Prior Year Equalized	0	0	0	0	0	0	No

Exemptions						
Exemption Type	Requested Date	Granted Date	Renewal Date	Prorate Date	Requested Amount	Granted Amount
Exempt Parcel	4/7/2008	4/7/2008	1/4/2024		0	0

No Farmland Information

No Genealogy Information

Taxing Bodies			
District	Tax Rate	Extension	No data
SCHUYLER/INDUSTRY UNIT 5	3.573410	\$0.00	
SCHUYLER COUNTY	1.097290	\$0.00	
RUSHVILLE TWP	0.491320	\$0.00	
RUSHVILLE CORP	1.336220	\$0.00	
SPOON RIVER JC 534	0.605290	\$0.00	
SCHUYLER CO HOSPITAL DISTRICT	0.386330	\$0.00	
RUSHVILLE TWP R&B	0.309350	\$0.00	
TOTAL	7.799210	\$0.00	

Section I. Operating Identity/Licensee

Attachment 3

Schuyler County District Hospital d/b/a Sarah D. Culbertson Memorial Hospital (“SDCMH”) is a Hospital District organized under ILCS 70/910-15.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HF134795**

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	L.D. NUMBER
12/31/2026		0002105
Critical Access Hospital		
Effective: 01/01/2026		

Sarah D. Culbertson Memorial Hospital
238 S Congress Street
Rushville, IL 62681

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4025001 2M 4/25

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

Exp. Date 12/31/2026

Lic Number 0002105

Date Printed 09/26/2025

Sarah D. Culbertson Memorial Hospital

238 S Congress Street
Rushville, IL 62681

FEE RECEIPT NO.

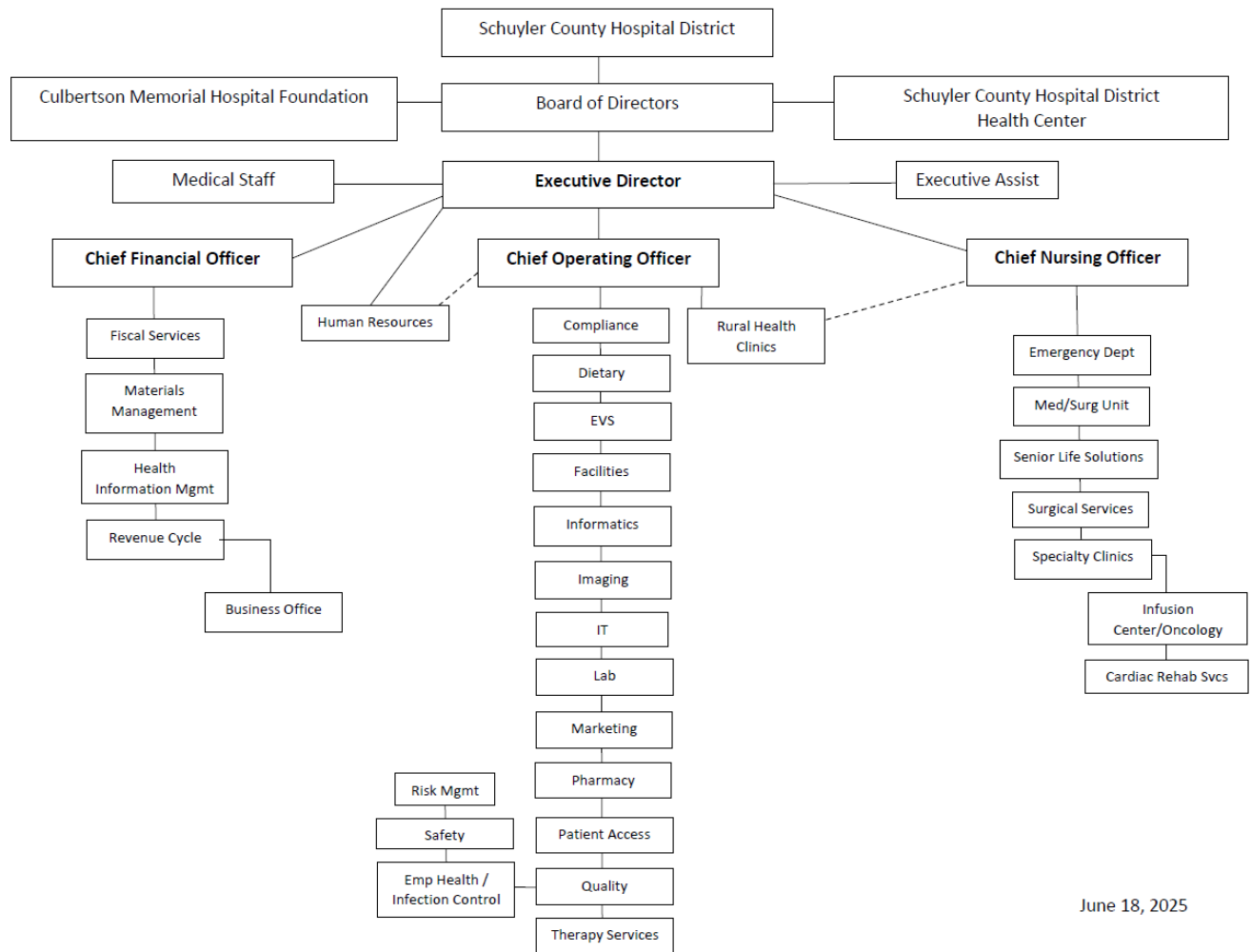
ATTACHMENT 3

Section I. Organizational Relationships

Attachment 4

A copy of the organizational chart for Sarah D. Culbertson Memorial Hospital is attached.

SARAH D. CULBERTSON MEMORIAL HOSPITAL ORGANIZATIONAL CHART



Section I. Flood Plain Requirements

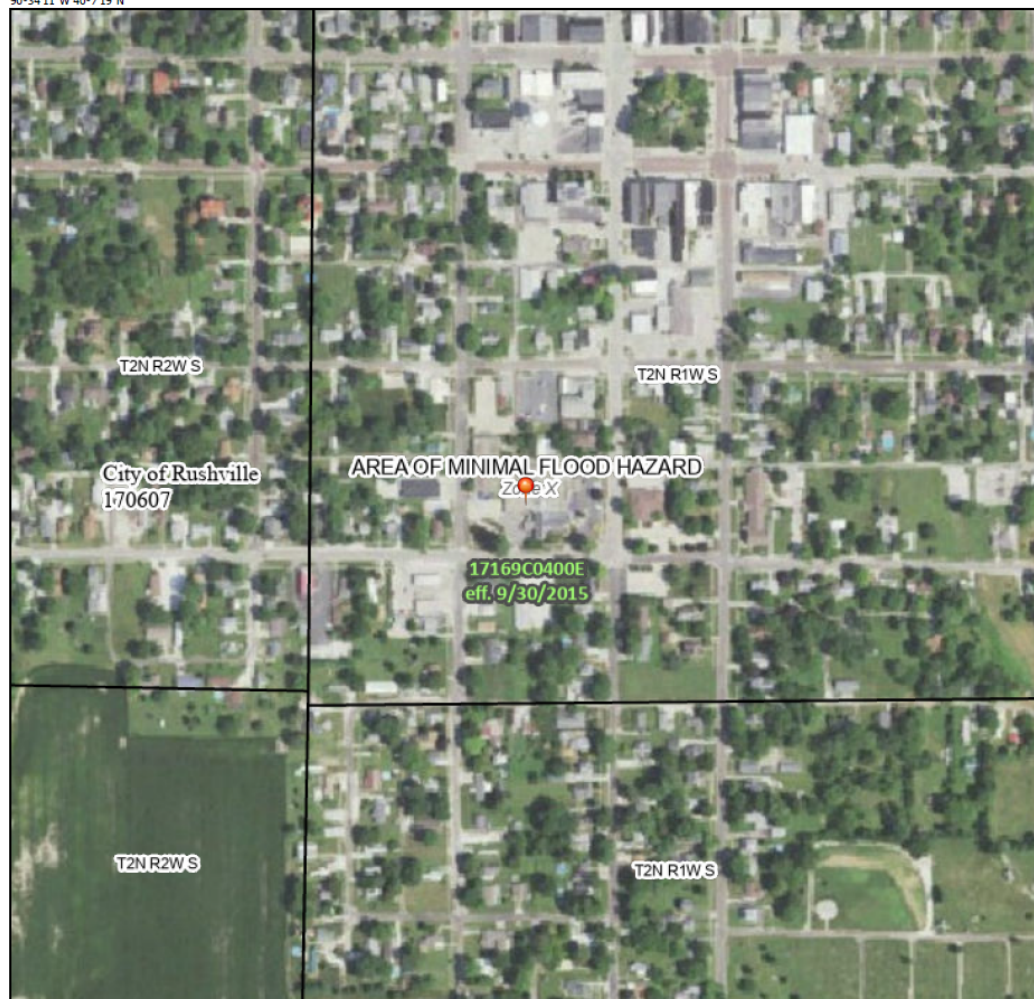
Attachment 5

Attestation that the site of the Project is not located in a flood plain and that the Project complies with the Flood Plain Rules under Illinois Executive Order #2005-5 is attached.

National Flood Hazard Layer FIRMette



90°34'11"W 40°7'19"N



0 250 500 1,000 1,500 2,000 Feet 1:6,000

Basemap Imagery Source: USGS National Map 2023

Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS		Without Base Flood Elevation (BFE) Zone A, V, A99
		With BFE or Depth Zone AE, AO, AH, VE, AR
OTHER AREAS OF FLOOD HAZARD		0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X
		Future Conditions 1% Annual Chance Flood Hazard Zone X
		Area with Reduced Flood Risk due to Levee. See Notes. Zone X
		Area with Flood Risk due to Levee Zone D
OTHER AREAS		NO SCREEN Area of Minimal Flood Hazard Zone X
		Effective LOMRs
GENERAL STRUCTURES		Channel, Culvert, or Storm Sewer
		Levee, Dike, or Floodwall
OTHER FEATURES		Cross Sections with 1% Annual Chance Water Surface Elevation
		Coastal Transect
		Base Flood Elevation Line (BFE)
		Limit of Study
OTHER FEATURES		Jurisdiction Boundary
		Coastal Transect Baseline
OTHER FEATURES		Profile Baseline
		Hydrographic Feature
MAP PANELS		Digital Data Available
		No Digital Data Available
		Unmapped

The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards.

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 10/6/2025 at 4:24 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

Section I. Historic Resources Preservation Act Requirements

Attachment 6

Attached is a letter to the Illinois Department of Natural Resources requesting confirmation that no historic, architectural or archaeological sites exists within the Project area.



Anna Pawlik
Phone: (312) 876-6958
anna.pawlik@saul.com
www.saul.com

November 10, 2025



VIA EMAIL

Carey L. Mayer, AIA
Deputy State Historic Preservation Officer
Illinois Department of Natural Resources
One Natural Resources Way
Springfield, Illinois 62701-1271
E-mail: SHPO.Review@Illinois.gov

**RE: Review to Determine Impact Upon Historic Resources
238 S. Congress Street, Rushville, Illinois 62681
Certificate of Need Application**

Dear Ms. Mayer:

This letter requests your comments as to whether a proposed project has historical, architectural or archeological impact. This request is made in connection with a Certificate of Need application to be filed soon with the Illinois Health Facilities and Services Review Board.

The project will be to construct an expended surgical suite and make additional improvements to the existing building. (the "Project") at Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital. The address for the hospital is 238 S. Congress Street, Rushville, Illinois 62681.

Enclosed please find a map showing the property together with a street view and satellite photos.

We would appreciate a letter in response that we can include as part of the CON application. If you have questions or comments, or need additional information, please contact me at (312) 876-6958.

I appreciate your assistance.

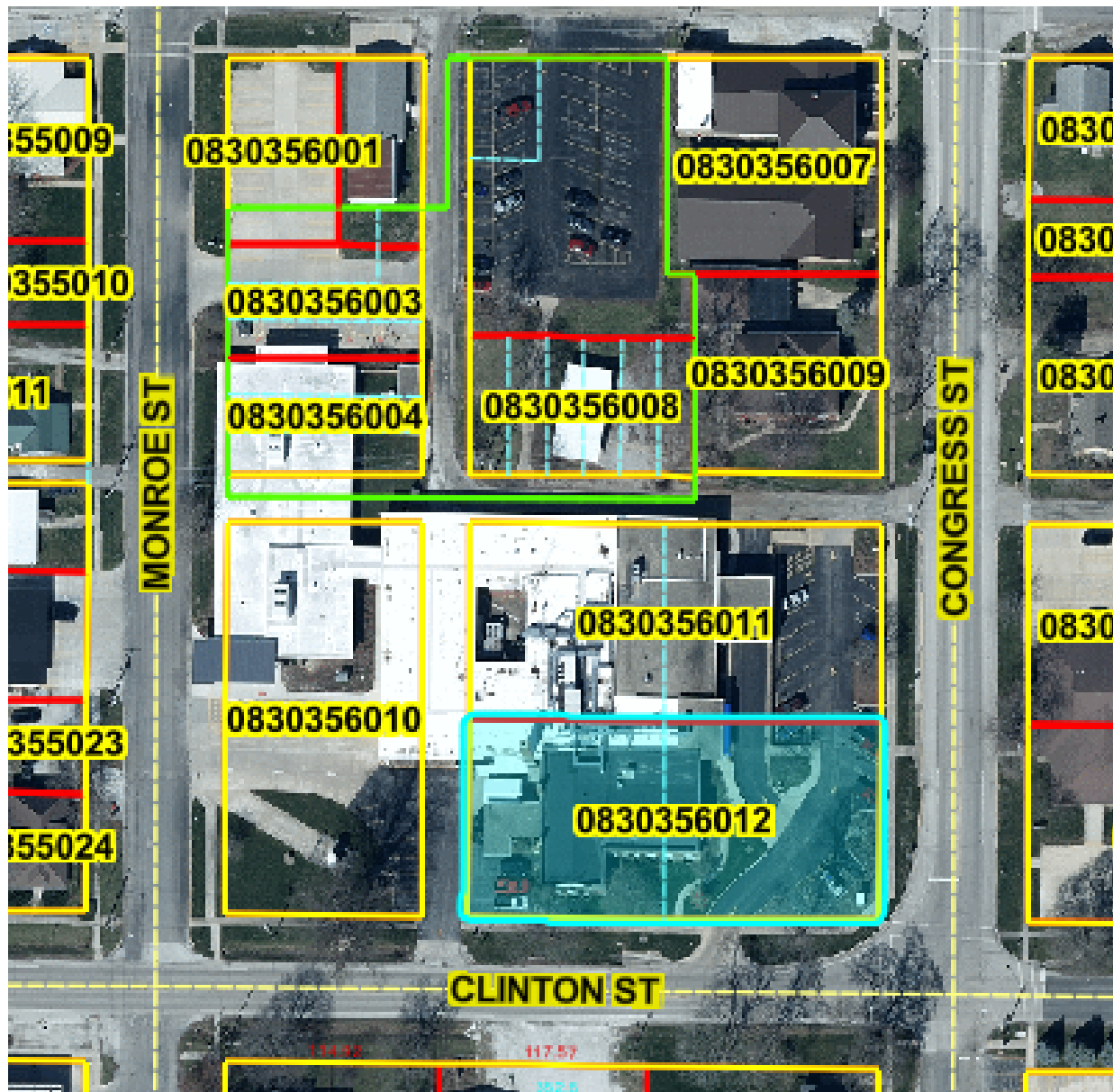
Very truly yours,

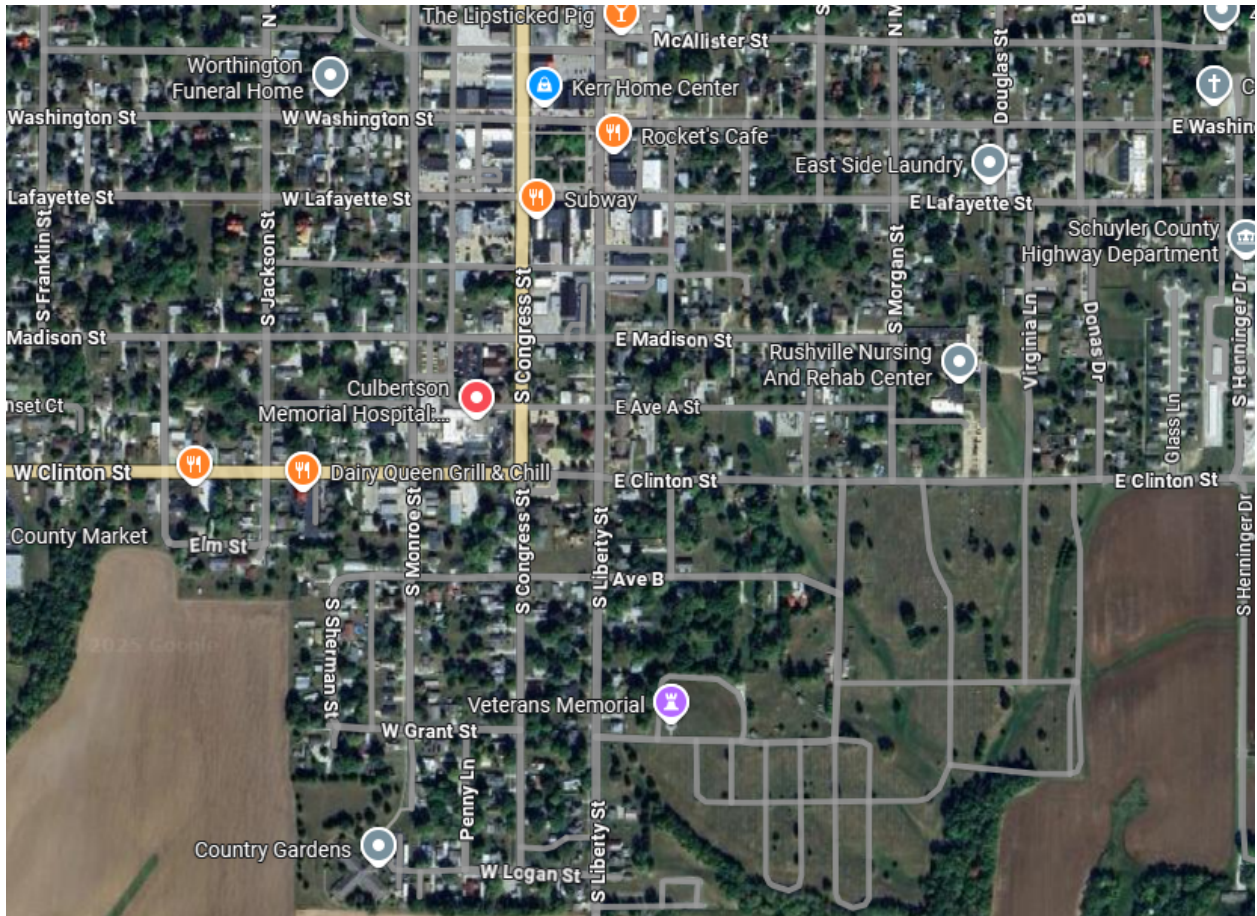
A handwritten signature in blue ink that reads "Anna Pawlik".

Anna Pawlik

ATTACHMENT 6







ATTACHMENT 6



Section I. Project Costs and Source of Funds

Attachment 7

Section 1120.110, Project Costs and Sources of Funds

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$159,712	\$136,051	\$295,763
Site Survey and Soil Investigation	\$19,386	\$16,514	\$35,900
Site Preparation	\$492,912	\$419,888	\$912,800
Off Site Work	0	0	0
New Construction Contracts	\$4,351,121	\$3,706,510	\$8,057,631
Modernization Contracts	\$5,228,186	\$4,453,640	\$9,681,825
Contingencies	\$749,239	\$638,241	\$1,387,480
Architectural/Engineering Fees	\$882,225	\$751,525	\$1,633,750
Consulting and Other Fees	\$251,345	\$214,109	\$465,454
Movable or Other Equipment (not in construction contracts)	\$1,751,212	\$53,187	\$1,804,399
Bond Issuance Expense (project related)	0	0	0
Net Interest Expense During Construction (project related)	\$170,100	\$144,900	\$315,000
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized	\$1,052,960	\$817,744	\$1,870,704
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	\$15,108,398	\$11,352,308	\$26,460,706
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages / financing			\$20,000,000
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			\$6,460,706
TOTAL SOURCES OF FUNDS			\$26,460,706
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Design & Construction	Total	Clinical	Non-Clinical
Preplanning Costs	\$ 295,763	\$ 159,712	\$ 136,051
Site Survey and Soil Investigation	\$ 35,900	\$ 19,386	\$ 16,514
Site Preparation	\$ 912,800	\$ 492,912	\$ 419,888
Off Site Work	\$ -	\$ -	\$ -
New Construction Contracts	\$ 8,057,631	\$ 4,351,121	\$ 3,706,510
Modernization Contracts	\$ 9,681,825	\$ 5,228,186	\$ 4,453,640
Hazardous Material Abatement below		\$ -	\$ -
Contingencies	\$ 1,387,480	\$ 749,239	\$ 638,241
Architectural/Engineering Fees	\$ 1,633,750	\$ 882,225	\$ 751,525
Net Interest Expense During Construction (project related)	\$ 315,000	\$ 170,100	\$ 144,900
Total	\$ 22,320,149	\$ 12,052,880	\$ 10,267,269

Consulting & Other Fees

IDPH Fees	\$ 24,552	\$ 13,258	\$ 11,294
CON Consulting Fees	\$ 75,000	\$ 40,500	\$ 34,500
CON Review Fee *	\$ 58,086	\$ 31,366	\$ 26,720
Civil Engineering Design Fee	\$ 148,000	\$ 79,920	\$ 68,080
Hazardous Materials Survey Fee	\$ 15,695	\$ 8,475	\$ 7,220
Building Permits	\$ 4,121	\$ 2,225	\$ 1,896
Legal Fees	\$ 35,000	\$ 18,900	\$ 16,100
Designer fee for Furnishings and Equipment coordination	\$ 25,000	\$ 13,500	\$ 11,500
Hospital Equipment Consultant fee	\$ 55,000	\$ 29,700	\$ 25,300
Loan Initiation Fee	\$ 25,000	\$ 13,500	\$ 11,500
Total	\$ 465,454	\$ 251,345	\$ 214,109

Other Costs to be Capitalized

IT	\$ 290,162	\$ 156,687	\$ 133,474
Artwork	\$ 66,960	\$ 36,159	\$ 30,802
Signage	\$ 44,640	\$ 24,106	\$ 20,535
Hazardous Material Abatement	\$ 767,891	\$ 414,661	\$ 353,230
Test & Balance	\$ 60,000	\$ 32,400	\$ 27,600
Fire Alarm	\$ 60,390	\$ 32,611	\$ 27,779
Nurse Call	\$ 93,000	\$ 93,000	\$ -
Telecom/Data	\$ 235,890	\$ 127,381	\$ 108,509
Access Control	\$ 168,730	\$ 91,114	\$ 77,616
CCTV	\$ 63,640	\$ 34,366	\$ 29,274
Paging/PA	\$ 19,400	\$ 10,476	\$ 8,924
	\$ -	\$ -	\$ -
Sub Total	\$ 1,870,704	\$ 1,052,960	\$ 817,744

Movable or Other Equipment (Not in Construction Contract)

Please see detailed list of Other/Movable Equipment			
Total	\$ 1,804,399	\$ 1,751,212	\$ 53,187
Grand Total	\$ 26,460,706	\$ 15,108,398	\$ 11,352,308

Detailed list of Other/Movable Equipment			
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Cart, Supply, Chrome, 36 inch	\$ 275		\$ 275
Cart, Supply, Chrome, 48 inch	\$ 900		\$ 900
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Dosing Station	\$ 850		\$ 850
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Pass-thru, Window, Central Sterile	\$ 13,090	\$ 13,090	
Sink, Clean-up Workstation (3-sink)	\$ 17,950	\$ 17,950	
Table, Work, Stainless, 48 inch	\$ 1,600	\$ 1,600	

ATTACHMENT 7

Ultrasonic Cleaner, Floor	\$ 38,285	\$ 38,285	
Cart, Utility, Stainless	\$ -	\$ -	
Washer/Disinfector, Electric	\$ 101,948	\$ 101,948	
Waste Can, 44-55 Gallon	\$ 125		\$ 125
Waste Can, Bio-Hazardous, 32-55 Gallon	\$ 120		\$ 120
Charger, Battery, Surgical Tool	\$ -	\$ -	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Incubator, Lab, Biological Indicator	\$ -	\$ -	
Sealer, Heat, Packaging	\$ -	\$ -	
Sterilizer, Low Temperature	\$ 56,652	\$ 56,652	
Sterilizer, Steam (Electric), Recessed, 1-Door	\$ 253,408	\$ 253,408	
Table, Instrument, Assembly	\$ 7,990	\$ 7,990	
Cart, Utility, Stainless	\$ -	\$ -	
Cart, Sterilizer, Floor Loading	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Board, Peg, General	\$ 920	\$ 920	
Cart, Supply, Chrome, 36 inch	\$ 300		\$ 300
Cart, Supply, Chrome, 48 inch	\$ 700		\$ 700
Cart, Supply, Chrome, 72 inch	\$ 5,525		\$ 5,525
Electrocardiograph (ECG), Interpretive	\$ -	\$ -	
Monitor, Physiologic, Bedside with Stand	\$ -	\$ -	
Scale, Clinical, Adult, Digital, Floor	\$ -	\$ -	
Stadiometer, Freestanding	\$ -	\$ -	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Cart, Supply, Chrome, 60 inch	\$ 400		\$ 400
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Flowmeter, Oxygen	\$ -	\$ -	
Diagnostic System, Integrated	\$ 1,800	\$ 1,800	
Light, Exam/Procedure, Single, Ceiling	\$ 4,277	\$ 4,277	
Monitor, Physiologic, Bedside, Critical Care	\$ -	\$ -	
Regulator, Suction, Intermittent/Continuous	\$ -	\$ -	

ATTACHMENT 7

Stretcher, Trauma / Surgery	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Flowmeter, Oxygen	\$ -	\$ -	
Diagnostic System, Integrated	\$ 1,800	\$ 1,800	
Light, Exam/Procedure, Single, Ceiling	\$ 4,277	\$ 4,277	
Monitor, Physiologic, Bedside, Critical Care	\$ -	\$ -	
Regulator, Suction, Intermittent/Continuous	\$ -	\$ -	
Stretcher, Trauma / Surgery	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Flowmeter, Oxygen	\$ -	\$ -	
Diagnostic System, Integrated	\$ 1,800	\$ 1,800	
Light, Exam/Procedure, Single, Ceiling	\$ 4,277	\$ 4,277	
Monitor, Physiologic, Bedside, Critical Care	\$ -	\$ -	
Regulator, Suction, Intermittent/Continuous	\$ -	\$ -	
Stretcher, Trauma / Surgery	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Dispenser, Hand Sanitizer, Wall-Mount	\$ 86		\$ 86
Waste Can, Open Top	\$ 225		\$ 225
Bracket, Chemicals, Wall Mount	\$ 80	\$ 80	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Medication, Host	\$ -	\$ -	
Dispenser, Medication, Auxiliary	\$ -	\$ -	
Refrigerator, Pharmaceutical, Undercounter	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Waste Can, 03-19 Gallon	\$ 53		\$ 53

ATTACHMENT 7

Waste Can, 03-19 Gallon	\$ 13		\$ 13
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Hamper, Linen	\$ 175	\$ 175	
Waste Can, Bio-Hazardous	\$ 75		\$ 75
Waste Can, Rollout	\$ 170		\$ 170
Cart, Supply, Chrome, 48 inch	\$ 300		\$ 300
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Clipper, Surgical	\$ -	\$ -	
Defibrillator, Monitor, w/Pacing	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Flowmeter, Oxygen	\$ -	\$ -	
Diagnostic System, Integrated	\$ 1,800	\$ 1,800	
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Laryngoscope Set, Video	\$ -	\$ -	
Light, Exam/Procedure, Single, Ceiling	\$ 12,857	\$ 12,857	
Stand, Mayo, Foot-Operated	\$ -	\$ -	
Monitor, Physiologic, Bedside, Critical Care	\$ -	\$ -	
Cart, Procedure, General	\$ -	\$ -	
Regulator, Suction, Intermittent/Continuous	\$ -	\$ -	
Sink, Scrub, 1-Bay, Stainless Steel	\$ 4,955	\$ 4,955	
Stretcher, Trauma / Surgery	\$ -	\$ -	
Ventilator, Transport, EMS	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Chair, Clinical, Recliner, Treatment	\$ -	\$ -	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43

ATTACHMENT 7

Flowmeter, Oxygen	\$ -	\$ -	
Diagnostic System, Integrated	\$ 1,800	\$ 1,800	
Monitor, Physiologic, Vital Signs, Wall Mount	\$ -	\$ -	
Regulator, Suction, Intermittent/Continuous	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Wheelchair, Adult, Large	\$ -	\$ -	\$ -
Cart, Housekeeping, Polymer	\$ -		\$ -
Rack, Mops / Brooms	\$ 85		\$ 85
Waste Can, 44-55 Gallon	\$ 125		\$ 125
Dispenser, Cleaning Solution	\$ 450		\$ 450
Cart, Housekeeping, Polymer	\$ -		\$ -
Rack, Mops / Brooms	\$ 85		\$ 85
Waste Can, 44-55 Gallon	\$ 125		\$ 125
Disinfector, Room, Ultraviolet, Mobile	\$ -		\$ -
Dispenser, Cleaning Solution	\$ 450		\$ 450
Cart, Housekeeping, Polymer	\$ -		\$ -
Rack, Mops / Brooms	\$ 85		\$ 85
Waste Can, 44-55 Gallon	\$ 125		\$ 125
Hamper, Linen	\$ 175	\$ 175	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
CT Scanner, Multi-Slice, 64-320 Slice	\$ 632,000	\$ 632,000	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Injector, Contrast Media, Mobile	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Densitometer, Bone, Whole Body	\$ 72,000	\$ 72,000	
Waste Can, Open Top	\$ 21		\$ 21
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	

ATTACHMENT 7

Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Mixer, Vortex	\$ -	\$ -	
Ultrasound, Imaging, Cardiac / Echo	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Waste Can, Open Top	\$ 225		\$ 225
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Chair, Clinical, Exam, Ultrasound	\$ -	\$ -	
Compression Unit, Extremity Pump, Intermittent	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Table, Imaging, Ultrasound	\$ -	\$ -	
Ultrasound, Imaging, Multipurpose	\$ -	\$ -	
Vascular Diagnostic System, Non-Invasive	\$ -	\$ -	
Warmer, Gel	\$ -	\$ -	
Washer/Disinfector, Transducer, Wall Mount	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
X-Ray Unit, General Radiography, Digital	\$ 178,000	\$ 178,000	

ATTACHMENT 7

Analyzer, Lab, Blood Culture	\$ -	\$ -	
Analyzer, Lab, Blood Typing	\$ -	\$ -	
Centrifuge, General Purpose, Countertop	\$ -	\$ -	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Freezer, Plasma, Undercounter	\$ -	\$ -	
Viewer, Agglutination	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Analyzer, Lab, Chemistry	\$ -	\$ -	
Analyzer, Lab, Blood Gas / pH / Electrolyte / Metabolite	\$ -	\$ -	
Analyzer, Lab, Chemistry/Drug, Point-of-Care	\$ -	\$ -	
Analyzer, Lab, Coagulation, Plasma	\$ -	\$ -	
Analyzer, Lab, Urinalysis, Semi-Automated	\$ -	\$ -	
Analyzer, Lab, Hematology	\$ -	\$ -	
Analyzer, Lab, DNA Amplification	\$ -	\$ -	
Analyzer, Lab, Sedimentation Rate	\$ -	\$ -	
Analyzer, Lab, Hematology	\$ -	\$ -	
Centrifuge, General Purpose, Countertop	\$ -	\$ -	
Centrifuge, General Purpose, Countertop	\$ -	\$ -	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 50		\$ 50
Dispenser, Soap, Wall-Mount	\$ 86		\$ 86
Freezer, Laboratory, Undercounter	\$ -	\$ -	
Hood, Fume, Benchtop, Vented	\$ -	\$ -	
Incubator, Lab, General, Compact	\$ -	\$ -	
Microscope, Binocular	\$ -	\$ -	
Mixer, Rocker	\$ -	\$ -	
Printer, Label, Barcode	\$ -	\$ -	
Refrigerator, Laboratory, 2 door	\$ -	\$ -	
Scanner, Barcode, Sample	\$ -	\$ -	
Stainer, Slide, Hematology/ Cytocentrifuge	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Chair, Clinical, Blood Draw	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Cart, Procedure, Phlebotomy	\$ -	\$ -	
Pass-thru, Specimen	\$ 850	\$ 850	

ATTACHMENT 7

Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Refrigerator, Domestic with Freezer	\$ -	\$ -	
Cart, Supply, Chrome, 60 inch	\$ 1,925		\$ 1,925
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Oven, Domestic, Microwave, Countertop	\$ 125		\$ 125
Refrigerator, Medical Grade, Undercounter w/Freezer	\$ 1,800	\$ 1,800	
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Pass-thru, Chamber, Cleanroom	\$ 1,200	\$ 1,200	
Waste Can, Open Top	\$ 21		\$ 21
Cabinet, Compounding Aseptic Containment Isolator	\$ -	\$ -	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Pass-thru, Chamber, Cleanroom	\$ 1,200	\$ 1,200	
Refrigerator, Pharmaceutical, Undercounter	\$ -	\$ -	
Cart, Supply, Chrome, 36 inch	\$ 275		\$ 275
Cart, Supply, Chrome, 48 inch	\$ 300		\$ 300
Cart, Supply, Chrome, 48 inch	\$ 300		\$ 300
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Hood, Horizontal Laminar Flow	\$ -	\$ -	
Hood, Vertical Laminar Flow	\$ 9,738	\$ 9,738	
Cart, Supply, Chrome, 48 inch	\$ 300		\$ 300
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Hood, Horizontal Laminar Flow	\$ 7,497	\$ 7,497	
Packaging System, Meds, Unit Dose	\$ -	\$ -	
Refrigerator, Pharmaceutical, 1 door	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53

ATTACHMENT 7

Services, Freight/Shipping	\$ 924		\$ 924
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Cart, Supply, Chrome, 36 inch	\$ 300		\$ 300
Cart, Supply, Chrome, 72 inch	\$ 425		\$ 425
Cabinet, Warming, Dual, Freestanding	\$ -	\$ -	
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Pump, Flushing, Endoscope Channel	\$ -	\$ -	
Pass-thru, Window, Central Sterile	\$ 13,090	\$ 13,090	
Shelf, Wall-Mount	\$ 135	\$ 135	
Sink, Clean-up Workstation (2-sink)	\$ 16,038	\$ 16,038	
Sink, Endoscope Flush, 1-Bay	\$ -	\$ -	
Sink, Scrub, 2-Bay, Stainless Steel	\$ 6,910	\$ 6,910	
Tester, Leak, Endoscope	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Cart, Supply, Linen, 48 inch	\$ -	\$ -	
Coffee Maker, Dispenser	\$ -	\$ -	
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Ice Machine, Dispenser, Nugget, Countertop	\$ -		\$ -
Oven, Domestic, Microwave, Countertop	\$ -		\$ -
Refrigerator, Domestic with Freezer	\$ -		\$ -
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Waste Can, 03-19 Gallon	\$ 13		\$ 13
Hamper, Linen	\$ 175	\$ 175	
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Cart, Anesthesia, Controlled Access	\$ -	\$ -	
Anesthesia Machine, General	\$ -	\$ -	
Bucket, Kick	\$ -	\$ -	
Camera, Endoscopy, Control Unit	\$ -	\$ -	
Cabinet, OR Console, Supply	\$ 16,167	\$ 16,167	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	

ATTACHMENT 7

Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Electrosurgical Unit, Bipolar/Monopolar	\$ -	\$ -	
Generator, Radio Frequency	\$ -	\$ -	
Insufflator, CO2	\$ -	\$ -	
Light, Surgical, Dual, Ceiling with Monitor Arm	\$ 30,103	\$ 30,103	
Stand, Mayo, Foot-Operated	\$ -	\$ -	
Monitor, Physiologic, Vital Signs	\$ -	\$ -	
Monitor, Video, 26 - 32 inch, Medical Grade	\$ -	\$ -	
Cart, Procedure, Endoscopy	\$ -	\$ -	
Stand, Basin, Single	\$ -	\$ -	
Smoke Evacuation, Surgical	\$ -	\$ -	
Light Source, LED	\$ -	\$ -	
Table, Surgical, Major	\$ -	\$ -	
Tourniquet System, General	\$ -	\$ -	
Table, Work, Stainless	\$ -	\$ -	
Warmer, Patient, Hypothermia	\$ -	\$ -	
Waste Can, 20-31 Gallon	\$ 130		\$ 130
Video Integration, Surgical	\$ 63,665	\$ 63,665	
Cart, Anesthesia, Controlled Access	\$ -	\$ -	
Anesthesia Machine, General	\$ -	\$ -	
Bucket, Kick	\$ 350	\$ 350	
Camera, Endoscopy, Control Unit	\$ -	\$ -	
Cabinet, OR Console, Supply	\$ 16,167	\$ 16,167	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Electrosurgical Unit, Bipolar/Monopolar	\$ -	\$ -	
Generator, Radio Frequency	\$ -	\$ -	
Insufflator, CO2	\$ -	\$ -	
Light, Surgical, Dual, Ceiling with Monitor Arm	\$ 30,103	\$ 30,103	
Stand, Mayo, Foot-Operated	\$ 650	\$ 650	
Monitor, Physiologic, Vital Signs	\$ 25,000	\$ 25,000	
Monitor, Video, 26 - 32 inch, Medical Grade	\$ -	\$ -	
Cart, Procedure, Endoscopy	\$ -	\$ -	
Stand, Basin, Single	\$ 450	\$ 450	
Smoke Evacuation, Surgical	\$ -	\$ -	
Light Source, LED	\$ -	\$ -	
Table, Surgical, Major	\$ 45,000	\$ 45,000	
Tourniquet System, General	\$ -	\$ -	

ATTACHMENT 7

Table, Work, Stainless	\$ 875	\$ 875	
Warmer, Patient, Hypothermia	\$ 950	\$ 950	
Waste Can, 20-31 Gallon	\$ 130		\$ 130
Video Integration, Surgical	\$ 63,665	\$ 63,665	
Board, Peg, General	\$ 460	\$ 460	
Charger, Battery, Procedure Chair	\$ -	\$ -	
X-Ray Unit, C-Arm, Mobile	\$ -	\$ -	
Electrosurgical Unit, Bipolar/Monopolar	\$ -	\$ -	
Laryngoscope Set, Video	\$ -	\$ -	
Monitor, Video, 26 - 32 inch, Medical Grade	\$ -	\$ -	
Cart, Procedure, General	\$ -	\$ -	
Cart, Procedure, Endoscopy	\$ -	\$ -	
Printer, Video Image, Color	\$ -	\$ -	
Rack, Apron, Wall Mount	\$ 270	\$ 270	
Cart, Supply, Chrome, 60 inch	\$ 400		\$ 400
Cart, Supply, Chrome, 72 inch	\$ 1,275		\$ 1,275
Light Source, Xenon	\$ -	\$ -	
Stretcher, Procedure-Recovery	\$ -	\$ -	
Ultrasound, Imaging, Multipurpose	\$ -	\$ -	
Video System, Endoscopic	\$ -	\$ -	
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	

ATTACHMENT 7

Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43

ATTACHMENT 7

Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Bed, Electric	\$ -	\$ -	
Disposal, Sharps, Wall Mount	\$ 75	\$ 75	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Emesis Bag, Wall Mount	\$ 30	\$ 30	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Pump, Infusion, Single	\$ -	\$ -	\$ -
Stand, IV, Chrome	\$ -	\$ -	
Monitor, Physiologic, Vital Signs with Stand	\$ -	\$ -	\$ -
Table, Overbed, General	\$ -	\$ -	
Waste Can, Open Top	\$ 21		\$ 21
Cabinet, Storage, Clinical, Drying, Endoscope	\$ -	\$ -	
Cabinet, Warming, Dual, Freestanding	\$ -	\$ -	
Defibrillator, Monitor, w/Pacing	\$ -	\$ -	
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Cart, Procedure, General	\$ -	\$ -	
Washer/Disinfector, Endoscope	\$ -	\$ -	
Waste Can, 03-19 Gallon	\$ 53		\$ 53
Dispenser, Paper Towel, Surface Mount	\$ 50		\$ 50
Dispenser, Soap, Wall-Mount	\$ 86		\$ 86
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Disinfectant Wipes, Wall Mount	\$ 35		\$ 35

ATTACHMENT 7

Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Hamper, Linen	\$ 175	\$ 175	
Waste Can, Bio-Hazardous	\$ 75		\$ 75
Waste Can, Rollout	\$ 170		\$ 170
Cart / Truck, Utility	\$ 680		\$ 680
Dispenser, Glovebox, Triple, Wall-Mount	\$ 63	\$ 63	
Dispenser, Hand Sanitizer, Wall-Mount	\$ 43		\$ 43
Hamper, Linen	\$ 175	\$ 175	
Waste Can, Bio-Hazardous	\$ 150		\$ 150
Stretcher, Procedure-Recovery	\$ -	\$ -	
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Hamper, Linen	\$ 175	\$ 175	
Dispenser, Paper Towel, Surface Mount	\$ 25		\$ 25
Dispenser, Soap, Wall-Mount	\$ 43		\$ 43
Waste Can, Open Top	\$ 21		\$ 21
Discount	\$ (20,000)	\$ (20,000)	
Services, Freight/Shipping	\$ 26,600		\$ 26,600
Total	\$ 1,804,399	\$ 1,751,212	\$ 53,187
Grand Total	\$ 26,460,706	\$ 15,108,398	\$11,352,308

Section I. Cost Space Requirements

Attachment 9

Cost Space Requirements

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Emergency Dept	\$2,380,386	2061	2891	0	2891		
Surgery	\$5,255,194	3673	4842	4842	0		3673
Radiology	\$2,699,240	2841	3620	0	3620		
Pharmacy	\$656,307	863	832	0	832		31
Lab	\$1,375,940	962	1414	1414	0		962
Post Anesthesia Recovery	\$2,741,331	1298	2760	2760	0		1298
Total Clinical	\$15,108,398	11,698	16,359	9,016	7,343		5,964
NON-REVIEWABLE							
Public/Waiting/Chapel	\$2,517,855	2144	2852	1137	1715		
Administrative	\$2,678,239	2934	3450	0	3450		
Staff support / Holding	\$1,925,718	1960	2272	1023	1249		
Loading Dock / Canopies	\$534,395	900	450	450	0		450
Mechanical / Basement	\$2,629,073	18,288	16,756	1500	2096	13,160	1532
Stairs / Elevator	\$467,706	467	740	442	0	298	
Information Tech. / Elec.	\$599,322	397	808	0	808		
Total Non-clinical	\$11,352,308	27,090	27,328	4,552	9318	13,458	1982
TOTAL	\$26,460,706	38,788	43,687	13,568	16,661	13,458	7,946

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section III. Background of Applicant

Attachment 11

Section 1110.230, Background, Purpose of the Project and Alternatives

1. A listing of all health care facilities owned by the applicant, including licensing, and certification if applicable.

Schuyler County District Hospital d/b/a Sarah D. Culbertson Memorial Hospital (“SDCMH”) owns and operates a critical access hospital. Copies of the IDPH license and accreditation certification is attached.

2. A certified listing of any adverse action taken against any facility owned and/or operated by applicant during the three years prior to the filing of the application.

With the signatures on the Certification pages of this Certificate of Need Application, the applicant attests that, to the best of its knowledge, no adverse action has been taken against any Illinois health care facility owned and/or operated by it during the three years prior to the filing of this CON Application. Further, with the signatures provided on the Certification pages of this CON application, each of the applicants authorizes the Health Facilities and Services Review Board and the Illinois Department of Public Health access to any documents which it finds necessary to verify any information submitted, including but not limited to official records of IDPH or other States agencies and records of nationally recognized accreditation organizations.

3. Authorization permitting HFSRB and DPH access to documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other States; when applicable; and the records of nationally recognized accreditation organizations.

By its signature to this permit application the Applicant hereby grants the Review Board and the IDPH access to information to verify information in this application.

Section III. Purpose of Project

Attachment 12

Overview of Sarah D. Culbertson Memorial Hospital

Sarah D. Culbertson Memorial Hospital (“SDCMH”) is a 22-bed nonprofit Critical Access Hospital headquartered in Rushville, Illinois, serving a predominantly rural population across Schuyler, Brown, Cass, and Fulton counties. SDCMH has been a central figure within the Schuyler County community since the hospital opened in 1921. SDCMH was incorporated under the Illinois Hospital District Law in 1950 and continues to operate as a non-profit organization and an essential healthcare provider across the region.

Overview of Project

The current primary clinical area of the hospital building was constructed in 1952, over 70 years ago, and is in need of improvements to meet modern standards. SDCMH completed a Master Facility Plan that outlined an extensive list of needed improvements, more than could be feasibly undertaken at one time. After careful review, it prioritized several elements that are the basis for these improvements in this Project.

The Project has several components including (i) replacing aging infrastructure and mechanical equipment, (ii) removing the obsolete 1920 original building to allow for construction of a 12,645 sf South Addition (including partial Basement) to accommodate a new Surgery department and to (iii) replace the existing Laboratory. The Project also includes a 1,355 sf proposed East Addition to accommodate a new main entry and other renovations (clinical and non-clinical) to accommodate improved Imaging, Pharmacy, Emergency, Administrative and public areas.

Purpose

Description of how the project will provide health services that improve health care or well-being of the market area population to be served.

The purpose of this Project is to make needed improvements to the existing Rushville hospital so that it can continue to provide ongoing access to quality care in the Rushville and the Schuyler County area.

Our service area, like other rural areas of Illinois and the nation general, face ongoing health care challenges, including an aging population, a shortage of health care providers, and often extended travel times for patients to receive care. *Almost 80% of inpatient admissions are people aged 65 or older.¹ 79% of our inpatients are Medicare and over 10% are Medicaid.² For outpatient care, 43% are Medicare and 23% are Medicaid.³*

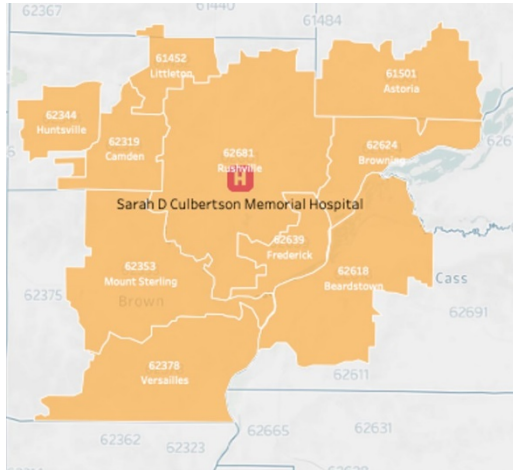
¹ Source: SDCMH 2024 Annual Health Questionnaire

² Source: SDCMH 2024 Annual Health Questionnaire. For reporting purposes, Medicare and Medicaid numbers include related managed care programs.

³ Source: SDCMH 2024 Annual Health Questionnaire

Primary Service Area (PSA)

SDCMH is the only hospital within its primary market area. As such, SDCMH remains the region's central provider of hospital services and is well-situated to reach a majority of the rural-area population with key hospital services.



SDCMH defines its Primary Area (PSA) by zip code and includes the following rural communities⁴

Sarah Culbertson Hospital Market Area ZIP Codes			
County	Town/City	ZIP Code	Total Population
Schuyler	Rushville	62681	5717
Schuyler	Camden	62319	240
Schuyler	Huntsville	62344	20
Schuyler	Littleton	61452	146
Schuyler	Browning	62624	266
Schuyler	Frederick	62639	213
Brown	Mount Sterling	62353	5006
Brown	Versailles	62378	814
Cass	Beardstown	62618	7318
Fulton	Astoria	61501	1646

⁴SDCMH 2026 Community Health Needs Assessment

There is no other hospital geographically close for Schuyler County residents. Patients needing to access care would need to travel considerable distances to another hospital. SDCMH works collaboratively with other Western Illinois hospitals who share the challenges of rural health. We are pleased to have letters of support for our project from many of these hospitals and physician groups.

Distance (in miles) to Regional Hospitals				
Hospital	Hospital Type	City	County	Distance (miles)
Memorial Hospital	CAH	Carthage, IL	Hancock	50
McDonough District Hospital	PPS	Macomb, IL	McDonough	28
Mason District Hospital	CAH	Havana, IL	Mason	33
Jacksonville Memorial Hospital	CAH	Jacksonville, IL	Morgan	39
Illini Community Hospital	CAH	Pittsfield, IL	Pike	45
St Johns Hospital	PPS	Springfield, IL	Sangamon	56
Blessing Hospital	PPS	Quincy, IL	Adams	55

Identify the Existing Problems or Issues that Need to be Addressed and How the Issues will be Addressed

The challenge for patients is to have access to care near their homes and to ensure that access to care continues into the future.

By their rural nature, Critical Access Hospitals operate with much lower volumes than more urban hospitals. Historically, CAHs have been relied on an enhanced Medicare reimbursement structure to be financially sustainable. The Medicare structure is quickly changing from a fee-for service model to a managed care model through programs such as Medicare Advantage plans. CMS has stated a goal to move the majority of seniors to managed care by 2030. The challenge for CAHs is that Medicare Advantage patients are treated as commercial payers which diminishes medicare reimbursement. Also, recent changes in federal policy will create more financial stress on rural hospitals. These changes require hospitals such as SDCMH to adapt to continue to meet the needs of rural communities.

SDCMH engaged Stroudwater to assist in planning for the future. This study confirmed that many patients were traveling well over 50 miles for outpatient procedures. This is largely a challenge because of the antiquated perception of the SDCMH surgical facilities. Working with major local physician groups, particularly Springfield Clinic and Quincy Medical Group, we have developed a structure that can better allow patients to have their procedures performed locally. With a modern surgical suite with two ORs, instead of one OR and one procedure room, we can schedule a surgeon or other specialists to perform multiple procedures on a given day on a rotating schedule. We are pleased to have letters of support from QMG and Springfield Clinic.

Health Professional Shortage Areas & Medically Underserved Areas

Rural communities across the U.S. experience persistent medical underservice, documented by federal Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) designations. The environmental and geographic traits that define the SDCMH market area encompass vast agricultural landscapes and long travel distances between towns, creating natural barriers to timely healthcare access. Seasonal weather challenges, such as dangerous winter weather conditions, further constrain access for residents seeking health care services. See the CHNA, page 7, for detail quantifying the Health Professional Shortage and Medically Underserved data.

Surgical Suite Replacement/Expansion

The most pressing clinical need at the hospital is to replace the 72-year-old operating room and the one procedure room with two modern operating rooms. Attachment 31 of this application details the deteriorated conditions that require replacement. Also, the existing OR is too small to perform certain procedures. For example, there is insufficient room in the current OR for the equipment and staff needed to perform orthopedic procedures. This OR does not meet current IDPH minimum size requirements and functions only because it is grandfathered into compliance. Consequently, orthopedic physicians who see outpatients at SDCMH facilities are unable to perform the procedures at the hospital.

The Project also proposes replacing a small procedure room with an operating room. This would allow for a procedure to be performed in one OR while the other was cleaned and prepped for the next procedure.

We acknowledge that our surgical volume does not reach the utilization targets in the Board's state standards. Lower utilization for surgery or inpatient care is the norm for any critical access hospital and is to be expected. We believe that the two ORs are necessary. One OR not provide the efficiency required by the structure of today's physician outreach contracts. On days that SDCMH hosts outreach providers, said provider must evaluate / treat patients in a clinical office setting and perform surgical procedures. Efficiency is the key to allow outreach providers to perform the most amount of care and allow the outreach day to be financially viable for the hospital. Unlike large hospitals or systems, SDCMH employs no surgeons. Most surgeons do not live in Rushville and instead schedule days to come to our hospital to perform procedures. They want to be able to quickly move from one procedure in one OR to another procedure in a second OR, without waiting while an OR is cleaned and prepared. Requiring a surgeon to be idle while the one OR is prepared or cleaned is inefficient for both the surgeon and the hospital.

Non-Clinical Improvements – Infrastructure Replacement

The other major component to the Project is the replacement of aging infrastructure, some of which dates back to the original construction 70 years ago. Replacement of heating, plumbing, and electrical equipment is not glamorous, but is necessary if SDCMH is to be able to continue to care for residents in the community.

Unique Care with Dignity to Incarcerated Persons

The market area is also home to two state-operated correctional facilities: (1) the Western Illinois Correctional Facility is a medium security male prison located in Mt. Sterling, IL (Brown County) with a total population of 1,535 residents as of January 1, 2026, and a total capacity of 1,894 persons; (2) the Illinois Department of Human Services Treatment and Detention Facility is an involuntary residential treatment program for individuals returning from incarceration related to sexual offenses, which is located in Rushville, IL (Schuyler County) and has an estimated capacity of approximately 800 males. SDCMH is a primary provider of medical services for both facilities and cooperates with these facilities as needed to offer medical services to individuals in their custody.

In working with these state agency partners we are planning a unique feature to better meet these patients' needs. The design includes separate entrance and waiting areas for these patients. Presently, they must wait in the general waiting area, wearing orange jumpsuits and in handcuffs in custody of guards. The institutions have told us that some incarcerated people have avoided necessary medical treatment because they feel embarrassed about being seen in our public waiting room in this custodial condition. Working with these state agencies, and by creating separate public space, we believe we can treat these patients with greater dignity.



2026 COMMUNITY HEALTH NEEDS ASSESSMENT

Prepared By
Burrows Consulting

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Sarah D. Culbertson Memorial Hospital
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Rushville, IL 62681
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EXECUTIVE SUMMARY:

This Community Health Needs Assessment (CHNA) is designed to identify and prioritize the significant health needs of the community served by Schuyler County Hospital District, doing business as Sarah D. Culbertson Memorial Hospital (SCH). The priorities outlined in this report will guide SCH programs for improving community health, developing targeted health service programs, and collaborating with other organizations dedicated to enhancing health.

Summary of Key Findings

Key community health issues identified through this assessment include:

1. Obesity & diabetes
2. Heart disease
3. Poor self-reported health
4. Poor health behaviors (alcohol and tobacco use, teen pregnancy, physical inactivity)
5. Lack of prenatal care and labor & delivery services

Key barriers to health identified through this assessment include:

1. Low median income
2. Lack of access to transportation
3. Lower health literacy
4. Poor internet connectivity

Other factors impacting health outcomes within the community include:

1. An aging rural population
2. Geographic isolation from advanced medical facilities
3. A high percentage of adults insured through Medicare and projected growth in Medicare population

In response to these health needs, barriers, and other community conditions, anticipated future needs within the market area include improved chronic care management, expanded hospital services to address pre-existing conditions, investment in maternal healthcare infrastructure, and community collaborations to address social drivers of health (SDOH) which impact health outcomes.

CHNA Purpose

This CHNA report aims to identify and prioritize the key health needs of the community served by SCH. The identified priorities shape SCH's initiatives for community health improvement and benefit activities, as well as their partnerships with other organizations dedicated to enhancing health.

The CHNA reflects the identification and prioritization of health service needs in the local community. It also includes an analysis of the significant indices that reflect the health, wellness, and quality of life within the communities SCH serves. The Needs Assessment is used to align the healthcare needs of the western Illinois target population with the appropriate clinical staffing and services, thereby improving service delivery. It enables SCH to assess community needs, utilizing quantitative and qualitative data. It is further used to:

- (1) Identify health-related social needs to inform and improve healthcare services and outreach strategies.
- (2) Identify key access and service delivery gaps.
- (3) Guide future SCH service development and expansion in response to community needs.

EXECUTIVE SUMMARY CONT.

The CHNA allows SCH to prioritize resources and address the most pressing community health needs, utilizing evidence-based practices and patient-centered services. Based on data and information from the assessment, SCH's Board of Directors and administration assess SCH's success in meeting current and emerging healthcare needs within the market area.

CHNA Goals

The assessment has several goals, which include the identification and documentation of:

- Community health needs
- Health services offered in the market area
- Significant gaps in health needs and services offered
- Barriers to meeting any needs and services offered
- Obstacles to meeting any needs that may exist

ABOUT SARAH D. CULBERTSON MEMORIAL HOSPITAL

Sarah D. Culbertson Memorial Hospital (SCH) is a nonprofit Critical Access Hospital headquartered in Rushville, Illinois, serving a predominantly rural population across Schuyler, Brown, Cass, and Fulton counties. SCH has been a central figure within the Schuyler County community since the hospital opened in 1921, and since then the hospital has continued to pursue its mission to provide community access to quality care. SCH was incorporated under the Illinois Hospital District Law in 1950 and continues to operate as a non-profit organization and an essential healthcare provider across the region. Operating for more than 100 years, SCH is one of the oldest and most financially sound Critical Access Hospitals in the state, with key services including: cardiology, endocrinology, gastroenterology, general surgery, gynecology, hematology and oncology, imaging, infectious disease, an infusion center, laboratory, mental health, neurology, nuclear medicine, orthopedics, podiatry, pulmonology, therapy (physical, occupational, and speech therapy), urology, vascular surgery, and wound care.

SCH is the only hospital within its primary market area. Other than SCH, there is one other hospital serving the four-county area, which is located in northern Fulton County and is far removed from much of the SCH market area population. As such, SCH remains the region's central provider of hospital services and is well-situated to reach a majority of the rural-area population with key hospital services.

SCH operates its main hospital campus in the town of Rushville (the Schuyler County seat, located in the center of the four-county area), as well as operating three rural health clinics in Astoria (Fulton County), Beardstown (Cass County), and Rushville (Schuyler County), which extend access to primary, preventive, walk-in and specialty care across the region. These family medicine practices offer primary and preventive care, alongside well-child care, women's health, family planning, and walk-in services. SCH's Elmer Hugh Taylor Clinic (Cass County) and Rushville Family Practice (Schuyler County) are recognized by The Compliance Team, Inc. with Exemplary Provider Status, demonstrating outstanding patient care practices and meeting all Safety-Honesty-Caring® program quality standards.

Sarah D. Culbertson Memorial Hospital's Mission, Vision & Values

SCH advances a mission centered on delivering quality care that promotes community health and ensures residents receive trusted services close to home. Guided by its vision to become the hospital of choice, the organization is anchored in a core value framework built on collaborative communication, accountability, respect, ethical behaviors, and exceptional service. These principles shape every patient interaction and operational decision, reinforcing the hospital's longstanding commitment: "Here for you, right around the corner."

NEEDS ASSESSMENT

Defining the Market Area:

Sarah D. Culbertson Memorial Hospital (SCH), located in West-central Illinois, is the only hospital in the broad overall market area. The Primary Service Area encompasses ten ZIP codes within the communities of Astoria, Beardstown, Browning, Camden, Frederick, Huntsville, Littleton, Mount Sterling, Rushville and Versailles (62681, 62319, 62344, 61452, 62624, 62639, 62353, 62378, 62618, 61501), and four primary counties (Brown, Cass, Fulton, and Schuyler). More than 96% of SCH inpatient volume and over 88% of emergency volume originates from patients in the Primary Service Area communities. The region's rural characteristics include an agricultural economy, and a network of small towns dispersed across broad geographic areas. These environmental and geographic features, including low population density, farmland, river valleys, and limited public transit, shape how residents access healthcare, education, and social services. The Illinois River Valley and surrounding farmland define much of the region's topography and travel patterns.



County	Town/City	ZIP Code	Total Population
Schuyler	Rushville	62681	5717
Schuyler	Camden	62319	240
Schuyler	Huntsville	62344	20
Schuyler	Littleton	61452	146
Schuyler	Browning	62624	266
Schuyler	Frederick	62639	213
Brown	Mount Sterling	62353	5006
Brown	Versailles	62378	814
Cass	Beardstown	62618	7318
Fulton	Astoria	61501	1646

The four-county market area has a total population of 59,231, with a population density of 30 persons per square mile (compared to Illinois, which has a density of 229 persons per square mile). As of the 2020 Census, it was estimated that 100% of the population in Schuyler and Brown counties was rural, along with 61% of Fulton County and 52% of Cass County. The rural population faces geographic isolation from larger urban areas, and the nearest providers of specialty medical services are located more than one hour from SCH by car.

The table below details the relative population density of each market area county, compared to the state and national averages.

[1] Health Resources and Services Administration. GeoCare Navigator.



NEEDS ASSESSMENT

Total Population Across Market Area Counties ²			
Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Schuyler County, IL	6,826	437.30	16
Brown County, IL	6,320	305.73	21
Cass County, IL	12,826	375.75	34
Fulton County, IL	33,259	865.68	38
<i>Illinois</i>	<i>12,692,653</i>	<i>55,513.14</i>	<i>229</i>
<i>United States</i>	<i>332,387,540</i>	<i>3,533,298.58</i>	<i>94</i>

Rushville, Illinois is positioned within reasonable travel distance to several major cities, creating opportunities and challenges for residents seeking higher acuity healthcare or specialized services outside the immediate market area. SCH lies approximately 50 miles west of Springfield, Illinois, the nearest metropolitan hub and the primary referral destination for advanced medical and tertiary care. SCH is roughly 200 miles southwest of Chicago, Illinois, the largest urban center in the state and home to multiple specialty hospitals and academic medical centers. Additionally, SCH is located about 120 miles north of St. Louis, Missouri, a major regional medical corridor offering trauma centers and specialized care.

Located within the market area are four health department sites providing basic health services including primary care, WIC, family planning, nutrition assistance, Title X, public health services, disease prevention, and STI/HIV screening. SCH works closely with these departments to ensure coordination of services without overlap in care. There are three Veterans Affairs locations (Cass, Fulton, and Schuyler), and three Illinois Community Action Agencies in the market area. These agencies support the basic needs of the community by providing emergency food assistance, utility assistance, workforce development, scholarships, school supplies, Head Start, and Early Head Start education. Eleven non-profit organizations in the market area offer transitional housing and shelter for the homeless.

The market area is also home to two state-operated correctional facilities: (1) the Western Illinois Correctional Facility is a medium security male prison located in Mt. Sterling, IL (Brown County) with a total population of 1,535 residents as of January 1, 2026, and a total capacity of 1,894 persons; (2) the Illinois Department of Human Services Treatment and Detention Facility is an involuntary residential treatment program for individuals returning from incarceration related to sexual offenses, which is located in Rushville, IL (Schuyler County) and has an estimated capacity of approximately 800 males. SCH is a primary provider of medical services for both facilities, and cooperates with these facilities as needed to offer medical services to individuals in their custody.

[2] US Census Bureau, American Community Survey. 2019-23



NEEDS ASSESSMENT

Health Professional Shortage Areas & Medically Underserved Areas

Rural communities across the U.S. experience persistent medical underservice, documented by federal Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) designations. The environmental and geographic traits that define the SCH market area encompass vast agricultural landscapes and long travel distances between towns, creating natural barriers to timely healthcare access. Seasonal weather challenges, such as dangerous winter weather conditions and frequent flooding, further constrain access for residents seeking health care services.

The tables below detail primary care, dental health, and mental health Health Professional Shortage Areas (HPSAs) by location, type, and full-time equivalent (FTE) deficits, followed by an estimate of the number of additional providers needed to address the unmet need.

Health Professional Shortage Areas (HPSA) ³				
Discipline	County	Name	Type	FTE Shortage
Primary Care	Schuyler	Cass/Schuyler Counties	Geographic	3.55 FTE
Primary Care	Cass	Cass/Schuyler Counties	Geographic	
Primary Care	Fulton	LI-Fulton County	Low-Income Population	3.36 FTE
Dental Health	Fulton	LI - Fulton County	Low-Income Population	2.52 FTE
Dental Health	Cass	LI-Cass County	Low-Income Population	1.08 FTE
Dental Health	Brown	Brown County	Geographic	0.90 FTE
Dental Health	Schuyler	LI - Schuyler County	Low-Income Population	0.60 FTE
Mental Health	Schuyler	Schuyler/Cass/Brown Counties	Geographic	1.20 FTE
Mental Health	Cass	Schuyler/Cass/Brown Counties	Geographic	
Mental Health	Brown	Schuyler/Cass/Brown Counties	Geographic	

As detailed above, the market area is currently experiencing provider shortages of approximately 1.2 full-time equivalent (FTE) mental health providers, 5.1 FTE dental health providers, and 6.91 FTE primary care providers. These shortages highlight a need for a targeted increase in the number of providers needed to meet existing health needs. These current shortages, coupled with population characteristics, can be used to determine the appropriate number and type of providers which the hospital can add in the next five years to meet the existing need for health services across the community.

In addition to the HPSAs identified above, the table below details the areas within SCH's market area which are designated as Medically Underserved Areas (MUAs).

[3] Health Resources and Services Administration. HPSA Find Tool.

NEEDS ASSESSMENT

Medically Underserved Areas (MUA) ⁴				
Discipline	County	Name	Designation Type	Index of Medical Underservice
Primary Care	Schuyler	Schuyler County	Medically Underserved Area	56.8
Primary Care	Brown	Brown County	Medically Underserved Area	36.1
Primary Care	Cass	Cass County	Medically Underserved Area	57.4
Primary Care	Fulton	Astoria Service Area	Medically Underserved Area	48

The Index of Medical Underservice score for each MUA is determined on a scale of 0 to 100, where 0 indicates the highest degree of medical underservice, and 100 indicates a low degree of medical underservice. As there are no hospitals located in Brown County, Brown County exhibits the highest degree of medical underservice among market area counties with a score of 36.1.

Market Area Population to Provider Ratios ⁵						
Discipline	Schuyler	Brown	Cass	Fulton	Illinois	U.S.
Primary Care Physicians	—	6,330:1	6,330:1	2,750:1	1,220:1	1:310:1
Dentists	—	—	1,400:1	4,070:1	1,170:1	1,340:1
Mental Health Providers	750:1	260:1	140:1	1,080:1	280:1	290:1
Other Primary Care Providers	1,690:1	1,050:1	1,160:1	1,080:1	780:1	680:1

"—" Data Unavailable

The population to provider ratios detailed above also reveal the degree of medical underservice experienced within the community, as the population to primary care physician ratio is more than five times that of Illinois, indicating that there are too few primary care physicians to meet the current need for care in each county. While slightly lower than Brown and Cass counties, Fulton County exhibits a population to provider ratio more than double that of the state, indicating a significant lack of access to primary care. Similar ratios are seen across dental and mental health providers, with Fulton County experiencing an extreme shortage of dental providers, in particular, and Fulton and Schuyler counties having very few mental health providers per capita. In addition to increasing patient wait time, large population to provider ratios are also associated with provider burnout, further threatening the retention of providers in the rural market area [6].

[4] Health Resources and Services Administration. MUA/P Find Tool.

[5] County Health Rankings and Roadmaps. 2025.

[6] Britz J, Morgan Z, Nisaki D, Dai M, Bazemore A, Funk A. Panel Size, Organizational Drivers, and Burnout in Primary Care. The Annals of Family Medicine, 23 (Supplement 1). 2025. DOI: <https://doi.org/10.1370/afm.23.s1.8212>



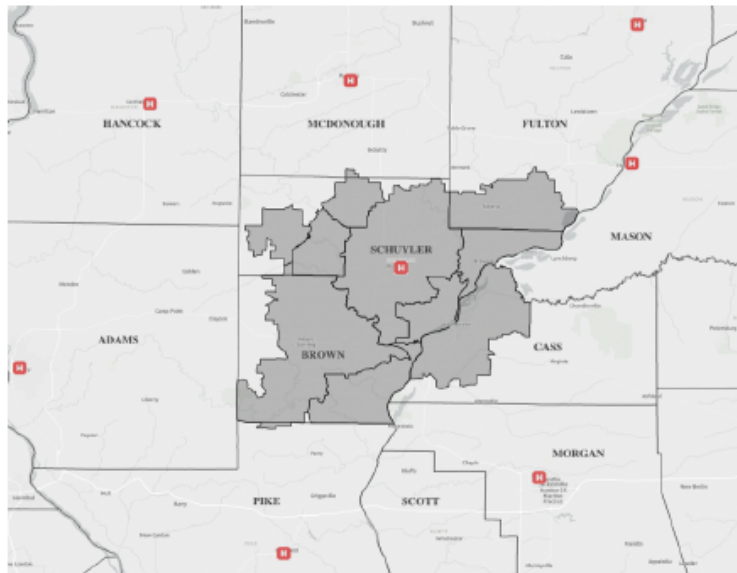
NEEDS ASSESSMENT

Available Health Resources

Public health services across Schuyler, Brown, Cass, and Fulton Counties form a critical safety-net infrastructure that directly complements and strengthens the services provided by SCH. In a rural market area with limited provider availability and transportation challenges, the presence of county health departments enables SCH to focus on specialties, acute, inpatient, and outpatient clinical care while relying on community based support systems to address early intervention and outreach.

The Schuyler County Health Department, located in Rushville, provides WIC, family case management, tobacco cessation, breast and cervical cancer screenings, and laboratory services, helping to reduce preventable hospital admissions. The Fulton County Health Department, with locations in Canton, Astoria, and Cuba, extends the reach of SCH through emergency preparedness, family planning, immunizations, WIC, STI testing, and dental sealant programs. Brown County Health Department, located in Mt. Sterling, provides communicable disease investigation, immunizations, WIC, STI testing, child passenger safety checks, and breast and cervical cancer screenings. These services complement SCH by improving preventive screening rates and promoting safer maternal and child health outcomes, while serving as a community referral source. Cass County Health Department, with offices in Virginia and Beardstown, enhances SCH's care continuum through home health and hospice services, dental services (Virginia location), and youth-focused programming through Teen REACH, which supports long-term health stability by addressing social and development determinants of health.

Additionally, three Veterans Affairs offices service this region with offices in Cass, Fulton, and Schuyler Counties. Three Illinois Community Action Agencies operate within the market area, addressing social needs through emergency food and utility assistance, workforce development, scholarships, and early childhood programming.



NEEDS ASSESSMENT

The table below details each hospital's designation as either a Critical Access Hospital (CAH) or a Prospective Payment System (PPS) hospital, and the county served by each [7].

Distance (in miles) to Regional Hospitals				
Hospital	Hospital Type	City	County	Distance (miles)
Memorial Hospital	CAH	Carthage, IL	Hancock	50
McDonough District Hospital	PPS	Macomb, IL	McDonough	28
Mason District Hospital	CAH	Havana, IL	Mason	33
Jacksonville Memorial Hospital	CAH	Jacksonville, IL	Morgan	39
Illini Community Hospital	CAH	Pittsfield, IL	Pike	45
St Johns Hospital	PPS	Springfield, IL	Sangamon	56
Blessing Hospital	PPS	Quincy, IL	Adams	55

SCH plays a primary role in delivering care to the market area through the operation of three Rural Health Clinics (RHC): Community Medical Clinic Astoria (Fulton County), Rushville Family Practice (Schuyler County), and the Elmer Hugh Taylor Clinic (Cass County). These clinics serve as critical access points for primary care and chronic disease management.

Three additional RHCs operate within the market area: Memorial Physician Services (Cass County), Quincy Medical Group (Brown County), and Blessing Hospital (Brown County). The Cass County Health Clinic in Beardstown is the only Federally Qualified Health Center (FQHC) in the market area. This limited supply of primary care providers underscores SCH's role in meeting the health needs of the community through its RHC sites and maintaining access to essential outpatient services throughout the region.

Residents across Schuyler, Cass, Brown, and Fulton counties rely on access to SCH providers and local emergency medical service providers for stabilization and transport when advanced care is needed. EMS providers by county are as follows:

- Schuyler: Schuyler County Ambulance Services
- Cass: LifeStar Ambulance Service and Echo Response EMS
- Brown: Brown County Ambulance Service
- Fulton: Fulton County Emergency Medical Association and Fulton County Paramedics Base 2

[7] Centers for Medicare & Medicaid Services (CMS), Quality, Certification, and Oversight Reports (QCOR) Basic Search Tool, U.S. Department of Health and Human Services.



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Community Characteristics

The four-county market area spans a predominately rural landscape having a total population of 59,231, with a population density of 30 persons per square mile (compared to Illinois, which has a density of 229 persons per square mile). Census data confirms rural residency predominates the area as it was reported that 100% of the population in Schuyler and Brown counties were rural, along with 61% of Fulton County and 52% of Cass County. This contrasts with urban areas of the state where higher population density supports broader provider availability and a broader healthcare infrastructure.

Market Area Urban and Rural Population ⁸		
Location	% of Population that is Rural	% of Population that is Urban
Schuyler County, IL	100.00%	0.00%
Brown County, IL	100.00%	0.00%
Cass County, IL	51.99%	48.01%
Fulton County, IL	60.79%	39.21%
Illinois	13.07%	86.93%
United States	20.00%	80.00%

Although Rushville is geographically connected to metropolitan areas, distance remains a defining barrier for the rural community. SCH lies approximately 50 miles from Springfield, Illinois, the nearest metropolitan hub; 200 miles from Chicago, the largest urban center in the state; and 120 miles from St. Louis, Missouri, a major regional medical corridor offering trauma centers and specialized care.

Median Household Income

All four counties in the market area fall below the state median income (\$81,702), with Fulton County having the lowest median income, at just 71.7% of the state median income and Brown County having the highest income, at 88.4% of the state median income. These income shortfalls are consistent with rural economic patterns and have direct implications for healthcare access and social determinants of health.

Market Area Median Household Income ⁹		
Location	Median Household Income	% of Illinois Median Income
Schuyler County, IL	\$66,059	80.9%
Brown County, IL	\$72,288	88.4%
Cass County, IL	\$64,907	79.4%
Fulton County, IL	\$58,617	71.7%
Illinois	\$81,702	100%
United States	\$78,538	96.1%

[8] US Census Bureau, Decennial Census. 2020.

[9] US Census Bureau, American Community Survey. 2019-23



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Sex/Gender Distribution

Across the rural market area, the percentage of the population identified as female is significantly lower than the percentage of the population identified as male. This is consistent with broader national trends, where rural areas are more predominantly male, and urban areas are more predominantly female. This is reflected within the market area, with the two counties (Schuyler and Brown) with a 100% rural population reflecting the greatest proportion of male population at 55.01% and 62.42% respectively.

Market Area Male/Female Distribution ¹⁰			
Location	Total Population	% Female	% Male
Schuyler County, IL	6,826	44.99%	55.01%
Brown County, IL	6,320	37.58%	62.42%
Cass County, IL	12,826	51.10%	48.90%
Fulton County, IL	33,259	47.89%	52.11%
Illinois	12,692,653	50.60%	49.40%
United States	332,387,540	50.50%	49.50%

Age Distribution

The median age in Schuyler county is 10 years older than the U.S. on average, indicating an older population within the market area. This is reflected in a percentage of the population aged 0-17 which is 5 percentage points lower than the U.S. and the state of Illinois on average. The table below provides an overview of age distribution across market area counties.

Market Area Age Distribution ¹¹				
Location	Median Age	Under 18 Years	18-64 Years	65+ Years
Schuyler County, IL	48.8	17.29%	57.56%	25.15%
Brown County, IL	40.9	17.44%	66.36%	16.20%
Cass County, IL	38.1	24.49%	56.94%	18.57%
Fulton County, IL	43.7	19.74%	59.18%	21.08%
Illinois	38.9	22.13%	62.31%	16.56%
United States	38.7	22.16%	62.28%	16.56%

[10] US Census Bureau, Decennial Census. 2020.

[11] US Census Bureau, Decennial Census. 2020.



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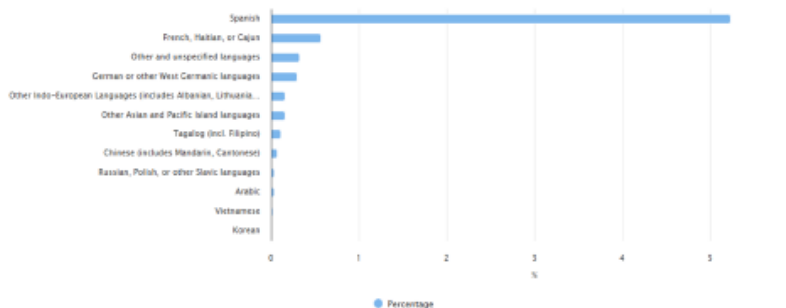
Race

Studying racial demographics is essential, as health disparities tied to race and structural inequities often persist in rural and predominately white communities when data are not intentionally examined [12]. Demographic analysis enables health systems to tailor culturally responsive care and ensure equitable outcomes across populations. Schuyler, Brown, Cass, and Fulton Counties are predominantly white, with white residents comprising between approximately 75.59% and 92.95% of the population. Black residents represent the largest singular minority group, most notably in Brown County at 17.26%, while representing less than 5% in remaining counties. At first glance the population appears largely homogeneous, however, in aggregate, the Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and other/multiple races represent a range of approximately 2% in Schuyler County and nearly 18% in Cass County. The table below describes racial and ethnic demographics within the market area.

Location	White	Black / African American	Asian	America Indian / Alaska Native	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Races
Schuyler Co.	92.25%	4.66%	0.66%	0%	0%	0.44%	1.99%
Brown Co.	75.59%	17.26%	0.03%	0.84%	0%	3.04%	3.24%
Cass Co.	77.69%	3.81%	0.80%	0.47%	0.58%	8.7%	8%
Fulton Co.	92.95%	2.60%	0.30%	0.60%	0%	0.73%	2.87%
Illinois	94.98%	1.89%	0.80%	0.07%	0.01%	1%	1.27%
United States	63.44%	12.36%	5.82%	0.88%	0.19%	6.6%	10.71%

Language

The illustration below identifies the language diversity within the market area, highlighting the languages spoken at home by residents [14]. While English remains the dominant language, a measurable portion of the population speaks a language other than English at home. Spanish is the most prevalent non-English language, spoken by approximately 5.23% of the population. Other languages are spoken by approximately 7.02% of the population. Although individually small, these language barriers can contribute to delays in care or to individuals not seeking needed care due to difficulty understanding the health system or communicating with staff.



[12] The Common Wealth Fund, Advancing Racial Equity in U.S. Health Care. April 2024.

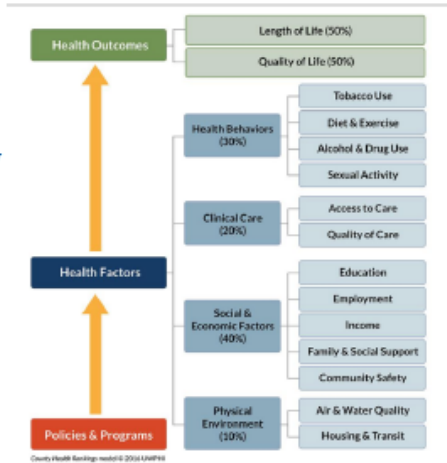
[13] U.S. Census Bureau, American Community Survey. 2019-2023.

[14] U.S. Census Bureau, American Community Survey. 2019-2023.

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Environmental, Social, and Economic Drivers of Health

In addition to disparities in access to clinical care across the rural region, SCH's market area faces numerous environmental, social, and economic conditions that create barriers to access for community members. Research is consistently revealing that access to medical care accounts for only 10-20% of modifiable contributors to healthy outcomes in a population; whereas, health-related behaviors, socioeconomic factors, and environmental factors (broadly called social drivers of health or SDOH) account for as much as 80-90% [15]. Key SDOH include (1) social and economic factors, such as education, employment, poverty, and social support; (2) the physical environment, including air quality, water quality, housing, and transportation; and (3) health behaviors, such as substance use, diet and exercise. The sections below provide an overview of key drivers of health within the SCH market area.



Social and Economic Factors

Poverty

In Schuyler County, one in five residents (19.28%) live below 100% of the Federal Poverty Level (FPL), and one in three (36%) have a low income at or below 200% FPL. On average, across the market area, this rate is approximately 12.74%, or 7,021 residents below 100% FPL, and 32.93%, or 18,151 residents with income below 200% FPL [16]. The table below provides an overview of income and poverty within the SCH market area.

Income and Poverty in the Market Area ¹⁷				
Location	Poverty (%)	Low-Income (%)	Children Eligible for Free & Reduced Price Lunch	Per Capita Income
Schuyler County, IL	19.28%	32.31%	45.6%	\$33,077
Brown County, IL	8.87%	29.56%	45.4%	\$26,526
Cass County, IL	10.90%	33.99%	66.2%	\$32,047
Fulton County, IL	12.64%	32.31%	53.9%	\$33,706
Illinois	11.72%	26.18%	47.6%	\$45,104
United States	12.44%	28.46%	54.7%	\$43,288

[15] National Academy of Medicine. Social Determinants of Health 101 for Health Care: Five Plus Five. n.d.

[16] U.S. Census Bureau, American Community Survey. 2019-2023.



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Among households living below 100% FPL, 56.6% are non-family households, where no children are present, among family households, single-female headed households are most likely to live in poverty, followed by married couples [18]. There are additional differences between social groups in the prevalence of poverty and low-income. For example, in Schuyler County, approximately 15.84% of the white population lives below the poverty level, whereas, 67.93% of the Black population, 44.4% of the Asian population, 52.31% of the multiracial population, and 85.71% of the population identified as “some other race” lives in poverty [19]. The table below provides an overview of differences in poverty between racial and ethnic groups.

Poverty Prevalence by Racial / Ethnic Group ²⁰							
Location	Total	White	Black / African American	American Indian / Alaska Native	Asian	Some Other Race	Multiple Races
Schuyler Co.	19.28%	15.84%	67.93%	—	44.44%	85.71%	52.31%
Brown Co.	8.87%	8.95%	2.70%	11.43%	—	0.00%	7.91%
Cass Co.	10.90%	11.30%	19.02%	8.33%	3.92%	7.98%	8.04%
Fulton Co.	12.64%	12.19%	45.00%	0.00%	5.26%	5.47%	34.03%
Illinois	11.72%	8.58%	24.53%	13.20%	10.08%	19.79%	15.15%
United States	12.44%	9.85%	21.28%	21.81%	9.93%	17.18%	18.24%

“—” Data Not Available

Employment/Unemployment

Employment and unemployment trends are significant drivers of health outcomes in a community. While unemployment is associated with poor health outcomes, the nature and type of employment can also significantly impact health.

Within the market area, the largest job sectors are:

1. Retail trade (Average wage: \$31,008)
2. Finance and insurance (Average wage: \$36,314)
3. Other services (Average wage: \$18,850)

These job sectors vary from the state on average, in which the top job sector is health care and social assistance and the average wage is \$66,464 [21]. The market area job sectors are important, in that these three traditionally carry lower average wages than major sectors across the state (healthcare at \$66,464, retail trade at \$40,389, and professional/scientific/technical services at \$99,564). The lower average wage of top job sectors within the SCH market area contributes to lower-income households, which is associated with poorer access to health care, and increased likelihood of being uninsured or publicly insured. Unemployment rates across the market area are consistent with state and national trends. The table below provides an overview of key employment characteristics in the market area.

[17] U.S. Census Bureau, American Community Survey. 2019-2023.

[18] U.S. Census Bureau, American Community Survey. Households Living Below the Poverty Level. 2019-2023.

[19] U.S. Census Bureau, American Community Survey. 2019-2023.

[20] U.S. Census Bureau, American Community Survey. 2019-2023.

[21] US Department of Commerce, US Bureau of Economic Analysis. 2022.



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Market Area Employment Trends (August 2025) ²²				
Location	Labor Force	Number Employed	Number Unemployed	Unemployment Rate
Schuyler Co.	2,774	2,651	123	4.4%
Brown Co.	2,567	2,485	82	3.2%
Cass Co.	5,889	5,622	267	4.5%
Fulton Co.	15,032	14,342	690	4.6%
Illinois	6,552,743	6,245,786	306,957	4.7%
United States	172,278,673	164,452,381	7,826,293	4.5%

Unemployment is a significant contributor to health outcomes, as individuals who are unemployed report greater feelings of depression, anxiety, low self-esteem, demoralization, worry, and physical pain, as well as tending to suffer more from stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease, and arthritis [23].

Unemployment is a significant contributor to health outcomes, as individuals who are unemployed report greater feelings of depression, anxiety, low self-esteem, demoralization, worry, and physical pain, as well as tending to suffer more from stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease, and arthritis [24]. The table below provides an overview of healthcare coverage in market area counties.

Insurance Status of Market Area Population ²⁵						
Location	Uninsured	Employer Coverage	Medicaid	Medicare	Non-Group	Military / VA
Schuyler Co.	8.12%	40.6%	19%	17.6%	12.0%	2.73%
Brown Co.	2.73%	54.4%	12.7%	15.6%	13.4%	1.2%
Cass Co.	7.29%	48.6%	17.8%	15.2%	10.3%	0.833%
Fulton Co.	3.96%	46.9%	19.9%	18.2%	10.4%	0.762%
Illinois	6.95%	52.6%	16.7%	12.7%	10.1%	0.905%
United States	8.55%	47.6%	17.3%	12.3%	12.6%	1.62%

The percentage of residents without health insurance varies across the market area, but is notably higher than the state in both Schuyler and Cass Counties. While the percentage of individuals with employer coverage in market area counties is consistent with state and national averages, the percentage of those with Medicare is significantly higher across all market area counties, reflective of an older population. The percentage of residents using Medicaid is also slightly higher than the state average in three of four counties, likely indicating the presence of a lower-income population.

[22] US Department of Labor, Bureau of Labor Statistics. 2025 - August.

[23] Healthy People 2030. Employment, Literature Summary. n.d.

[24] Healthy People 2030. Increase the proportion of people with health insurance — AHS-01.

[25] U.S. Census Bureau, American Community Survey. 2019-2023.



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Education & Health Literacy

Education is a key driver of health outcomes. Educational attainment is strongly associated with life expectancy, health behaviors, and morbidity rates across a community, as well as having predictive implications for lifetime income, insurance status, and healthcare access [26].

Educational Attainment in Market Area Counties ²⁷						
Location	No High School Diploma	High School Only	Some College	Associate's Degree	Bachelor's Degree	Graduate / Professional Degree
Schuyler Co.	8.0%	40.0%	23.7%	9.4%	12.6%	6.3%
Brown Co.	20.4%	40.3%	16.5%	7.7%	11.7%	3.4%
Cass Co.	13.3%	42.4%	17.7%	6.7%	15.0%	5.0%
Fulton Co.	9.1%	37.7%	23.4%	12.2%	12.1%	5.6%
Illinois	9.7%	25.3%	19.5%	8.3%	22.3%	14.9%
United States	10.6%	26.2%	19.4%	8.8%	21.3%	13.7%

Across market area counties, approximately 50% of residents have less than or only a high school education – this rate is 15 percentage points higher than both the state and national averages. While there is a similar proportion of market area residents with some college or an associate's degree, the percentage of residents with a bachelor's degree is only half that of the state and national averages, and the percentage with a graduate or professional degree is only one third of the state and national averages.

Lower educational attainment is also associated with lower health literacy and decreased likelihood that one will utilize regular preventive care. Rural older populations are also likely to have lower health literacy, placing the market area population at greater risk of foregoing needed medical care: A recent study estimated that only 3% of adults aged 65+ years were proficient with health literacy skills [28].

Area Deprivation Index

The Area Deprivation Index (ADI) ranks neighborhoods and communities relative to all neighborhoods across the nation (National Percentile) or relative to other neighborhoods within just one state (State Percentile). The ADI is calculated based on 17 measures related to four primary domains (Education; Income & Employment; Housing; and Household Characteristics). The overall scores are measured on a scale of 1 to 100 where 1 indicates the lowest level of deprivation (least disadvantaged) and 100 is the highest level of deprivation (most disadvantaged). The table below provides an overview of the ADI scores across market area counties.

[26] The Lancet Public Health (2020). Education: a neglected social determinant of health. The Lancet. Public health. 5(7), e361. [https://doi.org/10.1016/S2468-2667\(20\)30144-4](https://doi.org/10.1016/S2468-2667(20)30144-4)

[27] U.S. Census Bureau, American Community Survey. 2019-2023.

[28] Chesser, A. K., Keene Woods, N., Smothers, K., & Rogers, N. (2016). Health Literacy and Older Adults: A Systematic Review. Gerontology & geriatric medicine. <https://doi.org/10.1177/2333721416630492>



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Area Deprivation Index State and National Percentiles ²⁹			
Location	Total Population (2020)	State Percentile	National Percentile
Schuyler County, IL	6,902	84	83
Brown County, IL	6,244	48	50
Cass County, IL	13,042	88	88
Fulton County, IL	33,609	82	80
<i>Illinois</i>	<i>12,812,508</i>	<i>49</i>	<i>53</i>
<i>United States</i>	<i>331,129,211</i>	<i>51</i>	<i>46</i>

ADI scores in the 80th percentile and higher indicate that the market area is facing a higher level of deprivation than 80% of communities across both Illinois and the U.S. The ADI further ranks neighborhoods from “least disadvantaged” to “most disadvantaged”, compared with other neighborhoods across the nation. The table below indicates the severity of disadvantage in market area communities according to these ratings.

Tiered Area Deprivation Index ³⁰				
Location	Least Disadvantaged	Moderately Disadvantaged	Highly Disadvantaged	Most Disadvantaged
Schuyler County, IL	0.00%	0.00%	34.16%	65.84%
Brown County, IL	0.00%	0.00%	17.97%	82.03%
Cass County, IL	0.00%	5.20%	0.00%	94.80%
Fulton County, IL	0.00%	2.30%	16.89%	80.81%
<i>Illinois</i>	<i>15.90%</i>	<i>30.78%</i>	<i>30.07%</i>	<i>23.25%</i>
<i>United States</i>	<i>27.23%</i>	<i>27.91%</i>	<i>24.52%</i>	<i>20.34%</i>

Importantly, the Tiered ADI ranks more than 95% of community members within market area counties as either “highly disadvantaged” or “most disadvantaged”, indicating a lack of essential elements and services that support a healthy, prosperous community.

[29] University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas. 2023.

[30] University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas. 2023.



NEEDS ASSESSMENT

Social Vulnerability Index

The Social Vulnerability Index (SoVI) measures the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, which may affect that community's ability to prevent human suffering and financial loss in the event of disaster. A higher SoVI score indicates higher social vulnerability. The table below details the relative SoVI scores for market area counties.

Social Vulnerability Index ³¹					
Location	Socioeconomic Theme Score	Household Composition Theme Score	Minority Status Theme Score	Housing & Transportation Theme Score	Social Vulnerability Index Score
Schuyler County	0.47	0.77	0.23	0.42	0.50
Brown County	0.25	0.22	0.60	0.91	0.48
Cass County	0.35	0.81	0.63	0.36	0.50
Fulton County	0.43	0.08	0.21	0.24	0.21
Illinois	0.51	0.40	0.72	0.59	0.55
United States	0.54	0.47	0.72	0.63	0.58

The market area counties exhibit a modest social vulnerability, indicating that the community has moderate infrastructure and community resources, enabling it to recover from disasters at a rate similar to or slightly faster than the state and nation on average. A higher SoVI score is generally seen in communities with high population density, greater community heterogeneity, and reliance on urban infrastructure that can be vulnerable in a disaster.

Food Insecurity

Food insecurity is also a concern for community members across the market area, where as many as 16% of community members experience food insecurity. The table below provides an overview of food security and access to healthy foods across the four-county area.

Access to Healthy Foods in SCH Market Area ^{32 33 34}				
Location	Food Insecure Population (%)	Food Insecure Children (%)	Population Receiving SNAP Benefits (%)	Limited Access to Healthy Foods (%)
Schuyler County, IL	16.5%	16.3%	10.0%	6%
Brown County, IL	12.4%	15.2%	9.8%	10%
Cass County, IL	13.5%	15.9%	17.5%	3%
Fulton County, IL	13.8%	19.0%	17.1%	5%
Illinois	13.1%	15.5%	15.8%	5%
United States	14.3%	19.2%	12.7%	6%

[31] Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP 2022.

[32] Feeding America, Map the Meal Gap, Food Insecurity among the Overall Population in Illinois, 2023.

[33] US Census Bureau, Small Area Income and Poverty Estimates, 2022.

[34] County Health Rankings and Roadmaps, 2025.



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Access to nutritious food is a significant driver of long-term health outcomes, and lack of access to sufficient nutrition is associated with poor dietary quality and increased risk of diet-related health conditions such as cardiovascular disease, diabetes, and certain cancers. Food insecurity is also associated with higher rates of chronic conditions and lack of access to adequate health services (due to co-occurring financial strain) [35]. A significant percentage of the population has limited access to healthy foods, defined as having low income and living far from a grocery store.

The service area also includes two USDA-designated rural Food Desert Census Tracts, which encompass the northern half of Schuylers County and the majority of the southern Fulton County communities encompassed by SCH's market area. The USDA designates a food desert when a census tract population meets the following low-income and low-access thresholds [36].

1. Low-income: A poverty rate of 20% or greater, or a median family income at or below 80% of the statewide or metropolitan area median family income;
2. Low-access: At least 500 persons and/or at least 33 percent of the population lives more than 1 mile from a supermarket or large grocery store (10 miles, in the case of rural census tracts).

In total, approximately 11.5% of the four-county population lives in a food desert census tract, including 29.9% of Schuylers County residents [37]. People living in food deserts, especially older adults, are more prone to diet-related illness and chronic conditions such as obesity, diabetes, and cardiovascular disease, potentially leading to an increased need for medical care [38]. Residents of a rural food desert are required to travel 10 miles or more to access healthy foods, placing considerable strain on households with one or fewer motor vehicles, as well as increasing the relative cost of food due to required travel.

Physical Environment

Factors within the physical or built environment can also have a significant impact on community health outcomes. Key environmental factors which may pose a barrier to community health include housing, internet access, transportation infrastructure, air quality, and water quality, among other factors.

Housing

The safety, stability, and quality of housing are important drivers of health outcomes. A lack of stable housing (both housing insecurity and homelessness) is associated with poorer physical and mental health, as well as increased mortality rates [39]. Poor housing conditions are associated with poor health outcomes, including the prevalence of respiratory infections, asthma, lead poisoning, injuries, and poorer mental health [40].

[35] Odum-Young, A., Brown, A. G. M., Agurs-Collins, T., & Glanz, K. Food Insecurity, Neighborhood Food Environment, and Health Disparities: State of the Science, Research Gaps and Opportunities. *The American journal of clinical nutrition*, 119(3), 850-861. <https://doi.org/10.1016/j.ajcnut.2023.12.019>, 2024.

[36] Ver Ploeg M, Naliph D, Williams R. Mapping Food Deserts in the United States. U.S. Department of Agriculture (USDA). Economic Research Service, 2011.

[37] US Department of Agriculture (USDA). Economic Research Service - Food Access Research Atlas, 2019.

[38] Kelli, H. et al. Living in Food Deserts and Adverse Cardiovascular Outcomes in Patients With Cardiovascular Disease. *Journal of the American Heart Association*, 8(4), e010694, 2019. <https://doi.org/10.1161/JAHA.118.010694>

[39] Taylor, L.A. Housing And Health: An Overview Of The Literature. *Health Affairs*, 2018.

[40] Krieger, J., & Higgins, D. L. (2002). Housing and health: time again for public health action. *American journal of public health*, 92(5), 758-768. <https://doi.org/10.2105/ajph.92.5.758>



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The tables below provide an overview of housing status in SCH market area counties.

Housing Affordability in Market Area Counties ⁴¹								
Location	Units Affordable at 15% AMI	Units Affordable at 30% AMI	Units Affordable at 40% AMI	Units Affordable at 50% AMI	Units Affordable at 60% AMI	Units Affordable at 80% AMI	Units Affordable at 100% AMI	Units Affordable at 125% AMI
Schuyler Co.	7.30%	21.86%	37.53%	50.90%	61.39%	77.77%	85.74%	89.47%
Brown Co.	4.73%	22.62%	34.59%	48.22%	59.41%	78.25%	84.83%	88.48%
Cass Co.	6.80%	22.81%	43.74%	56.69%	66.62%	81.69%	88.53%	91.33%
Fulton Co.	7.29%	22.17%	34.01%	46.47%	55.93%	71.43%	82.36%	87.23%
Illinois	4.17%	11.04%	18.36%	27.40%	36.76%	52.77%	68.96%	75.99%
United States	3.72%	8.55%	13.51%	20.32%	27.66%	43.24%	58.33%	68.13%

The data above reveal that housing is more affordable at the Area Median Income (AMI) of market area counties than across Illinois and the U.S. as a whole, with over 85% of available housing units being considered affordable at the AMI, compared to less than 70% of units across Illinois. Reflective of the relative affordability of housing in the market area, there are fewer households facing a housing cost burden, defined as spending more than 30% of annual household income on housing costs. The table below reflects housing cost burden across the market area.

Housing Cost Burden in Market Area Counties ⁴²			
Location	Total Households	Cost-Burdened Households (#)	Cost-Burdened Households (%)
Schuyler County, IL	2,732	457	16.73%
Brown County, IL	2,021	381	18.85%
Cass County, IL	5,135	874	17.02%
Fulton County, IL	13,902	2,722	19.58%
Illinois	5,001,904	1,387,767	27.74%
United States	127,482,865	37,330,839	29.28%

Housing quality is also a driver of health outcomes, with substandard conditions contributing to the potential for development of certain chronic or acute health conditions. Substandard housing is reported as the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. The table below details rates of substandard housing across the market area.

[41] US Census Bureau, American Community Survey, 2019-23.

[42] US Census Bureau, American Community Survey, 2019-23.



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Housing Quality in Market Area Counties ⁴³			
Location	Total Occupied Housing Units	Occupied Housing Units with One or More Substandard Conditions	Percent with One or More Substandard Conditions
Schuyler County, IL	2,732	534	19.55%
Brown County, IL	2,021	399	19.74%
Cass County, IL	5,135	1,002	19.51%
Fulton County, IL	13,902	2,870	20.64%
<i>Illinois</i>	<i>5,001,904</i>	<i>1,495,843</i>	<i>29.91%</i>
<i>United States</i>	<i>127,482,865</i>	<i>40,765,129</i>	<i>31.98%</i>

In all aspects of housing quality, availability, and affordability, the market area counties outperform both the state and the nation. The ability of market area residents to access affordable, quality housing is a positive contributor to long-term health.

Transportation

The rural market area is heavily reliant on the use of personal vehicles, with very few options for public transportation. Yet, a significant number of market area residents do not have access to personal vehicles. The table below details the number and percentage of households with no motor vehicle at home.

Households with No Motor Vehicle ⁴⁴			
Location	Total Occupied Households	Households with No Motor Vehicle (#)	Households with No Motor Vehicle (%)
Schuyler County, IL	2,732	137	5.01%
Brown County, IL	2,021	142	7.03%
Cass County, IL	5,135	246	4.79%
Fulton County, IL	13,902	680	4.89%
<i>Illinois</i>	<i>5,001,904</i>	<i>545,425</i>	<i>10.90%</i>
<i>United States</i>	<i>127,482,865</i>	<i>10,602,826</i>	<i>8.32%</i>

Of the 23,790 total households in the four-county area, 1,205 or 5.07% are without a motor vehicle. The highest concentrations of households with no motor vehicle are located in the communities of Mount Sterling (11.7%, Brown County), Beardstown (7.9%, Cass County), and Rushville (6.0%, Schuyler County). The heavy reliance on private transportation can place additional strain on low-income households who do not own a personal vehicle or who are not able to support transportation costs to access medical care. Recent research has revealed that 21% of U.S. adults without access to a personal vehicle or public transit options went without needed medical care in the previous year due to transportation barriers. Additionally, adults with a disability, adults who have low-income, adults who are publicly insured, and adults who identify as Black/African American are more likely to experience transportation barriers in accessing care than their counterparts [45].

[44] US Census Bureau, American Community Survey, Households with No Vehicle, Percent by Tract, 2019-23.

[45] Smith LB, Karpman M, Gonzalez D, and Morris S. More than One in Five Adults with Limited Public Transit Access Forgo Health Care Because of Transportation Barriers. Robert Wood Johnson Foundation. 2023.



NEEDS ASSESSMENT

Access to Broadband Internet

Access to high-speed internet is also a factor in one's ability to access essential community services, health information, and health providers. The Federal Communications Commission (FCC) reports a strong, statistically significant correlation between the adoption of broadband internet and improvements in community health outcomes: A 2015 study revealed that the least connected counties also experienced the highest rates of chronic disease; obesity prevalence was 25% higher and diabetes prevalence was 41% higher in counties with poor access to internet; and the least connected counties had poorer access to primary care, with higher rates of preventable hospitalization. A later study reported by FCC also revealed a reduction in diabetes prevalence correlated with adoption of high-speed internet across previously unconnected counties [46].

The table below provides an overview of broadband access in market area counties as of 2025.

Access to High-speed Internet in Market Area Counties ⁴⁷			
Location	Total # of Broadband Serviceable Locations	Access to DL ≥ 25 Mbps & UL ≥ 3 Mbps	Access to DL ≥ 100 Mbps & UL ≥ 20 Mbps
Schuyler County, IL	4,300	93.12%	67.77%
Brown County, IL	3,020	87.91%	80.99%
Cass County, IL	6,575	97.37%	92.14%
Fulton County, IL	18,087	96.65%	85.19%
Illinois	4,114,678	98.30%	95.60%
United States	116,414,099	97.08%	94.70%

The broader market area demonstrates significantly poorer connectivity than Illinois (95.6%) and the United States (94.7%) on average, ranging from a low of 67.77% in Schuyler County to a high of 92.14% in Cass County. Research by the FCC has classified access to high-speed internet as a social driver of health (SDOH) with potentially significant impacts on chronic disease and medical care. The potential benefits of increased internet connectivity across the market area would be improved access to online health resources and increased ability for SCH providers to serve patients through telehealth, reducing transportation barriers, as well as increased ability to remotely monitor chronic conditions. Future community health initiatives may include the adoption of greater telehealth and virtual care capacity as broadband internet becomes more available within the market area.

Air & Water Quality

Air and water quality are central built environment factors that directly impact human health, with air quality related to the prevalence of asthma and lung diseases, whereas water quality may impact the development of cancers, chronic conditions, or infectious diseases due to contaminants present.

While Cass, Brown, and Fulton counties are currently reporting no drinking water violations, Schuyler County is reporting that at least one system has reported drinking water violations in the last year [48][49]. The most recent Schuyler County water system violations included one in Rushville (Rushville, System No. IL1690200) dated in July of 2025, with compliance achieved by August 2025, and another dated January 2025 for the Browning water system (No. IL1690050), requiring public notification due to violations of the lead and copper rule [50].

[46] Federal Communications Commission. Studies and Data Analytics on Broadband and Health. n.d.

[47] FCC FABRIC Data. Additional data analysis by CARES. June, 2025.

[48] County Health Rankings and Roadmaps. 2025.

[49] National Institute on Minority Health and Health Disparities. HDPulse. United States Water Violations - Table. Drinking Water Violations in the Previous Year. 2023.

[50] Illinois EPA. Drinking Water Branch. Water System Details. 2025.



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Air quality reporting reveals levels of particulate matter in all four counties at levels lower than Illinois, on average, likely associated with location in a more rural area. The table below details air quality reports across market area counties.

Air Pollution: Particulate Matter ⁵¹	
Location	Micrograms per Cubic Meter of Fine Particulate Matter (2020)
Schuyler County, IL	7.9
Brown County, IL	7.7
Cass County, IL	8.0
Fulton County, IL	8.5
<i>Illinois</i>	<i>8.7</i>
<i>United States</i>	<i>7.3</i>

While market area counties demonstrate particulate matter rates slightly higher than the U.S. on average, the Environmental Protection Agency (EPA) has primary annual average standards of 12.0 micrograms per cubic meter, placing all market area counties within a normal, healthy range [52].

Health Behaviors

Health behaviors are the third category of SDOH with a significant impact on human and community health, accounting for as much as 30% of the known modifiable contributors to health outcomes. Health behaviors include tobacco use, diet and exercise, sexual activity, and use of drugs and alcohol, among other factors.

[51] County Health Rankings and Roadmaps. 2025.
[52] County Health Rankings and Roadmaps. 2025.



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The table below provides an overview of key health behaviors in market area counties.

Key Health Behaviors Across Market Area Counties						
Indicator	Schuyler	Brown	Cass	Fulton	Illinois	U.S.
Flu Vaccinations (%) ⁵³	36%	33%	42%	38%	51%	48%
Mammography Screening (%) ⁵⁴	43%	51%	36%	44%	45%	44%
Excessive Drinking (% of Adults) ⁵⁵	22%	21%	21%	21%	19%	19%
Adult Smoking ⁵⁶	18%	20%	18%	19%	13%	13%
Leisure Time Physical Inactivity	24%	26%	26%	25%	22%	23%
Teen Births ⁵⁷	13	—	30	24	13	16
Sexually Transmitted Infections (New Diagnoses per 100,000) ⁵⁸	311.3	—	561.0	209.0	568.8	495.0
STI - HIV Prevalence (Per 100,000) ⁵⁹	—	107.9	57.2	147.0	338.8	386.6
STI - Chlamydia Incidence (Per 100,000) ⁶⁰	148.52	15.89	452.52	264.28	557.72	492.2
STI - Gonorrhea Incidence	74.3	15.9	103.2	79.9	202.3	179.0

“—” Data Not Available

Flu Vaccination

The data above reveal that significantly fewer individuals across SCH market area counties receive regular flu vaccinations – lowest in Brown County at just 33% of the population. This rate is considerably lower than the 51% of Illinois residents who receive vaccinations. Annual vaccination has been shown to reduce flu-related doctor’s visits by 40% to 60% annually, potentially placing a greater burden on available healthcare resources due to a large portion of the population which does not receive the flu vaccine [61].

[53] County Health Rankings and Roadmaps. 2025.

[54] County Health Rankings and Roadmaps. 2025.

[55] County Health Rankings and Roadmaps. 2025.

[56] County Health Rankings and Roadmaps. 2025.

[57] County Health Rankings and Roadmaps. 2025.

[58] County Health Rankings and Roadmaps. 2025.

[59] Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022.

[60] Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022.

[61] Centers for Disease Control and Prevention. Benefits of the Flu Vaccine. Aug 2024.



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Mammography Screening

The percentage of women who complete recommended screening for breast cancer varies considerably among market area counties, ranging 36% in Cass County to 51% in Brown County, but on average, the market area screening rate is comparable to that across Illinois. Women who regularly receive breast cancer screenings have a 41% reduction in their risk of dying from breast cancer within 10 years [62]. An increase in mammography completion rates in the SCH market area has the potential to reduce overall breast cancer mortality.

Excessive Drinking

A greater percentage of adults across the SCH market area engage in excessive drinking, which is reported by more than one in five adults. Excessive drinking is associated with not just alcohol use disorder and mental health conditions, but also with higher rates of high blood pressure, heart disease, liver disease, stroke, digestive problems, and a weakened immune system [63].

Adult Smoking

A greater percentage of adults across the SCH market area are active smokers, ranging between 18% and 20%, compared to a state percentage of just 13% in Illinois. Smoking has significant impacts on both human health and the healthcare system. Smoking cigarettes is known to cause cancer, heart disease and stroke, lung diseases such as chronic obstructive pulmonary disease (COPD), type 2 diabetes, harmful reproductive health effects, and other diseases, including certain eye diseases and problems of the immune system. Cigarette smoking is also associated with increased utilization of healthcare services, increased healthcare costs, and missed work due to health conditions [64].

Leisure Time Physical Inactivity

A slightly higher percentage of adults in the SCH market area (24% - 26%) report no physical activity outside of work, compared to Illinois adults (22%) on average. Regular physical exercise is associated with a reduced risk of type 3 diabetes, cardiovascular disease, certain cancers, and infectious diseases. It is also known to help manage symptoms of existing chronic conditions[65].

[62] Duffy, S.W., et al. Mammography screening reduces rates of advanced and fatal breast cancers: Results in 549,091 women. *Cancer*, 126: 2971-2979. 2020. <https://doi.org/10.1002/cncr.32859>

[63] Centers for Disease Control and Prevention. Alcohol Use and Your Health. January 2025.

[64] Centers for Disease Control and Prevention. Cigarette Smoking. September 2024.

[65] Centers for Disease Control and Prevention. Benefits of Physical Activity. December 2025.



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Teen Births

Teen birth rates vary considerably across the market area, ranging as high as 30 births per 1,000 females ages 15-19 in Cass County, compared to a rate of just 13 births per 1,000 females ages 15-19 in Illinois. Adolescent pregnancy is associated with higher rates of preterm labor, lower Apgar scores for the newborn, and low birth weight; it is also associated with lower overall educational attainment, lower lifetime earnings, stigmatization, poorer mental health, and increased risk of abuse/neglect due to a confluence of factors [66]. Higher rates of teen births within the market area present an opportunity for increased reproductive health education and improved access to coordinated care for pregnant adolescents.

Sexually Transmitted Infections

Sexually transmitted infections (STIs), including HIV, chlamydia, and gonorrhea are significantly less prevalent within the market area than within Illinois on average. STIs are associated with increased risk of certain cancers, infertility, and pregnancy and childbirth complications [67]. The lower STI prevalence within the market area is a positive indicator of community health and is reflective of national trends within smaller, more rural communities. However, recent studies also reveal that screening rates for certain STIs may be artificially lower in rural communities due to stigma and poor access to reproductive health care, leading to the potential for a greater number of undiagnosed and untreated STIs in rural communities, compared to urban communities [68].

Key Health Indicators

Major Causes of Morbidity

As detailed in the chart below, residents in the market area report significantly higher levels of poor health than across the state of Illinois on average. Similar trends are noted for poor physical health and the number of days per month with physical distress. While asthma cases for the Medicare population are lower in the area, low birth weight, diabetes and heart disease maintain rates consistent with the state average. Falling in line with increased adult obesity cases, reports of high blood pressure in the Medicare population are prevalent. These instances carry over to mortality rates, which report higher than average premature age-adjusted mortality and a decrease in life expectancy. It is important to note the exponential incidence of cancer and to correlate equally elevated cancer mortality rates in the region. These numbers are indicative of a health provider shortage area and a population that may be unable to seek medical treatment due to health or health-related barriers to receiving care.

Indicator	Schuyler	Brown	Cass	Fulton	Illinois	U.S.
Poor or Fair Self-Reported Health (%) ⁶⁶	19%	21%	20%	20%	16%	17%
Poor Physical Health Days Per Month ⁶⁷	4.6	4.6	4.6	4.6	3.8	3.9
Frequent Physical Distress (%) ⁶⁷	13%	14%	14%	14%	12%	12%
Low Birth Weight (%) ⁶⁷	9%	7%	9%	8%	9%	8%
Diabetes Prevalence (%) ⁶⁷	11%	12%	11%	11%	11%	10%
Adult Obesity ⁶⁴	39%	41%	39%	39%	33%	34%
Cancer Incidence (All Sites, per 100,000)	483.0	499.3	461.3	524.6	459.2	444.4
High Blood Pressure (Medicare Population) ⁶⁸	70%	69%	70%	66%	60%	65%
Heart Disease (Medicare Population) ⁶⁸	22%	24%	26%	19%	22%	21%
Asthma (Medicare Population)	3.8%	2.4%	4.6%	3.7%	4.7%	5.0%
Preventable Hospital Stays (per 100,000 Medicare beneficiaries) ⁶⁷	1,427	3,638	3,181	2,841	3,239	2,666

[66] Diabelková, J., Rimárová, K., Docko, E., Urdzik, P., Houšnicková, A., & Argališová, I. Adolescent Pregnancy Outcomes and Risk Factors. *International journal of environmental research and public health*, 20(5), 4113. 2023. <https://doi.org/10.3390/ijerph20054113>

[67] World Health Organization. Sexually transmitted infections (STIs). September 2025.

[68] Amiri, S., Pham, C. D., Amram, O., Alcover, K. C., Oluwoye, O., Bravo, L., Sinberry, M., McDonnell, M. G., Roll, J. M., & Fresco, A. Proximity to Screening Site, Rurality, and Neighborhood Disadvantage: Treatment Status among Individuals with Sexually Transmitted Infections in Yakima County, Washington. *International journal of environmental research and public health*, 17(8), 2679. 2020. <https://doi.org/10.3390/ijerph17082679>



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Major Causes of Mortality

The market area consistently underperforms in almost every major cause of mortality indicating a systemic underinvestment in healthcare and healthcare infrastructure. Major causes of mortality within the market area include cancers, heart disease, and stroke. While these causes of death frequently appear among the leading causes of death across the U.S., service area mortality rates far exceed both the state and the nation for these three major causes or mortality, as detailed below. Life expectancy in the market area falls behind Illinois and U.S. averages, with Schuyler (75.2) and Fulton (75.0) counties demonstrating the greatest short-falls. Premature death data indicates a challenge, particularly in Schuyler County, where years of potential life lost indicate a significant burden of preventable mortality. Profoundly surpassing state and national numbers, cancer mortality rates suggest gaps in early detection and access to oncology services. Similarly, cardiovascular disease is an urgent area of concern as coronary heart disease and stroke mortality rates are vastly higher in the market area compared to the state and U.S. averages. Collectively these patterns are indicative of a healthcare sector under strain and a population experiencing unnecessary, preventable loss of life.

Major Causes of Mortality Across Market Area Counties						
Indicator	Schuyler	Brown	Cass	Fulton	Illinois	U.S.
Life Expectancy ⁷⁸	75.2	78.2	77.0	75.0	78.1	77.6
Premature Death (years of potential live lost per 100,000 population) ⁷⁹	10,900	6,200	7,700	8,700	7,600	8,100
Premature Age-Adjusted Mortality ⁸⁰	510	330	400	460	370	390
Cancer Mortality (per 100,000) ⁸¹	230.6	158.5	215.8	306.4	186.8	182.7
Coronary Heart Disease Mortality (per 100,000) ⁸²	124.2	80.8	141.7	157.7	97.1	111.0
Stroke Mortality (per 100,000) ⁸³	103.5	71.5	72.5	69.5	52.8	48.3
Lung Disease Mortality (per 100,000) ⁸⁴	85.7	—	58.0	102.5	41.3	44.9
Injury Deaths (per 100,000) ⁸⁵	86	62	84	79	80	87
Suicide Deaths (per 100,000) ⁸⁶	—	—	16	13	11	14
Motor Vehicle Crash (per 100,000) ⁸⁷	—	—	—	12.6	10.2	12.8

"—" Data suppressed due to low population

[69] County Health Rankings and Roadmaps. 2025.

[70] County Health Rankings and Roadmaps. 2025.

[71] County Health Rankings and Roadmaps. 2025.

[72] County Health Rankings and Roadmaps. 2025.

[73] County Health Rankings and Roadmaps. 2025.

[74] County Health Rankings and Roadmaps. 2025.

[75] Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2023.

[76] Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2023.

[77] County Health Rankings and Roadmaps. 2025.



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Implications & Health Strategies

The morbidity and mortality rates detailed above have important implications for west central Illinois health professionals. Key areas of concern within the market area include high rates of adult obesity, diabetes, heart disease, and poor self-reported health, as well as high rates of premature death and mortality due to cancer, stroke, and heart disease.

The higher prevalence of obesity, diabetes, and heart disease within the market area may be associated with provider shortages and barriers to accessing primary and preventive care (e.g., socioeconomic factors, environmental factors, and health behaviors), also present within the market area. Higher rates of these chronic conditions may also increase risk factors for cancer, stroke, and heart disease mortality. These rates, together, point to a need for increased access to primary and preventive care, as well as improved access to inpatient and outpatient hospital services for patients with preexisting chronic conditions. To improve community uptake of medical services, community initiatives and health strategies must also address key SDOH present within the community, including lower socioeconomic status, insurance status, access to transportation, and health literacy.

Sarah D. Culbertson Memorial Hospital (SCH) has supported community health and wellness within the market area for more than 100 years and is working to meet a broad range of community health needs. In addition to primary care and hospital services, SCH also addresses nutrition and food access through a mobile meals program supporting older adults recovering from surgery, a counseling program to address family and personal needs, and a charity care program through which patients can access financial assistance with hospital bills.

To continue meeting community needs and growing community capacity to address high rates of chronic conditions and mortality, future strategies must increase access to preventive care, access to health-related services, community health literacy, and uptake of expanded health services by community members.

Mental Health, Substance Use Disorder, and Suicide

According to the latest data from County Health Rankings & Roadmaps, the target counties exhibit high population to provider ratios reaching as high as 1,080 patients to one mental health provider, almost four times the state average. This data signifies a critical shortage of available mental health professionals in relation to the population as well as a pronounced burden of unmet need in the community.

Provider shortages likely exacerbate other mental health metrics available. Adults in the market area report more frequent poor or fair self-reported stress days, poor physical health days, and physical distress days than state averages. These conditions coexist with elevated levels of tobacco use and excessive alcohol consumption, both of which are strongly associated with worsening mental health, chronic disease progression, and increased risk of preventable mortality. Although rates of suicide deaths are suppressed due to a lack of available data, Cass and Fulton Counties both report an increase in suicides as compared to state averages.

^[78] County Health Rankings and Roadmaps. 2025.

^[79] County Health Rankings and Roadmaps. 2025.

^[80] County Health Rankings and Roadmaps. 2025.

^[81] Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

^[82] Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

^[83] Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

^[84] Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

^[85] County Health Rankings and Roadmaps. 2025.

^[86] County Health Rankings and Roadmaps. 2025.

^[87] Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



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Mental Health, Substance Use Disorder, and Suicide in the Market Area						
Indicator	Schuyler	Brown	Cass	Fulton	Illinois	U.S.
Poor of Fair Self-Reported Health (%) ⁸⁸	19%	21%	20%	20%	16%	17%
Poor Physical Health Days ⁸⁹	4.6	4.6	4.6	4.6	3.8	3.9
Frequent Physical Distress Days (%) ⁹⁰	13%	14%	14%	14%	12%	12%
Adult Smoking (%) ⁹¹	18%	20%	18%	19%	13%	13%
Excessive Drinking (% of Adults) ⁹²	22%	21%	21%	21%	19%	19%
Suicide Deaths (per 100,000) ⁹³	—	—	16	13	11	14

The behavioral health environment within the market area is characterized by structural frailty rather than isolated challenges. Limited availability of mental health providers constrains access to timely care, while elevated levels of self-reported mental distress suggests that many residents are navigating persistent psychological strain without adequate support. The community faces heightened vulnerability to escalating mental health conditions that contribute to broader patterns of chronic illness, shortened life expectancy, and a diminished quality of life. Together, these conditions indicate a need to invest in a mental health restructuring that strengthens workforce capacity and integrates behavioral health into primary care to stabilize outcomes and advance long-term population health across the region.

Key Community Health Needs in 2026

Women's Health & Family Planning Services

Access to women's health services in the region remains severely constrained, driven in part by the financial pressures associated with providing obstetric and family planning care in rural settings. Illinois Medicaid reimbursement for maternity services is a global fee averaging approximately \$900, encompassing the physician fee, facility charge, and antepartum care [94][95].

This unsustainable reimbursement structure forces many hospitals to operate obstetric units at a significant financial loss. As a result, most Illinois rural hospitals have closed their OB and labor and delivery programs, leaving large geographic areas without local maternity care. For women in the target market area, the nearest prenatal care providers and birthing hospitals are now more than an hour away, creating substantial barriers to timely and continuous prenatal and reproductive care.

Rather than withdrawing services, SCH has partnered with the Illinois Family Planning Program to rebuild access to prenatal and maternity care, positioning itself as the regional hub for women's health. The launch of the SCH Family Planning Program in 2025 demonstrates a strategic and necessary effort to reverse regional service erosion.

[88] County Health Rankings and Roadmaps. 2025
 [89] County Health Rankings and Roadmaps. 2025
 [90] County Health Rankings and Roadmaps. 2025
 [91] County Health Rankings and Roadmaps. 2025
 [92] County Health Rankings and Roadmaps. 2025
 [93] County Health Rankings and Roadmaps. 2025
 [94] Illinois Department of Healthcare and Family Services Physician Fee Schedule
 [95] Illinois Medicaid Billing Guide for Maternity Care Reimbursement



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Access to Inpatient Care

An increase in inpatient bed capacity represents an urgent need for the region. SCH is the sole inpatient care provider within an hour drive, positioning the hospital as the primary acute care provider for surrounding rural communities. As care complexity rises and population health needs increase, existing bed availability is no longer sufficient to meet demand.

Demographic data further intensifies these issues, with the market area experiencing a steadily aging population (the median age in Schuyler County is 10 years older than the U.S. on average) requiring more frequent inpatient services and chronic disease management. A recent study led by UCLA found that post-pandemic U.S. hospital occupancy has risen from a pre-pandemic average of 64% to 75%. Given the surge of hospitalizations expected as the population ages, national occupancy of adult hospital beds could reach 85% by 2032 if hospitalization rates and bed supply remain unchanged [96]. Without targeted service expansion, SCH's current inpatient infrastructure will likely result in delayed admissions, higher readmission rates, and adverse patient outcomes.

SCH plays a significant role in shaping the economic stability of Schuyler, Fulton, Brown, and Cass Counties, functioning not only as a healthcare provider, but also as one of the region's larger employers. In rural communities, hospitals commonly serve as anchor institutions that generate significant economic activity. The National Rural Health Association reports that Critical Access Hospitals (CAHs) significantly contribute to their community, producing an average of \$7.1 million in total wages and \$1.8 million in taxable retail sales annually [97]. Expansion of SCH's capacity and available services enables the provision of stable, high and moderate-wage jobs, directly influences household income security, and contributes to the reversal of the current negative outmigration (-6.12%^[98]) in the market area.

Investments in rural health care workforce development programs have demonstrated a return on investment of \$3.50 for every dollar spent. The multiplier effect of each healthcare job created in rural areas can support an additional one to two jobs in the local economy [99]. SCH's potential for expanded workforce development is, therefore, imperative to the community economic sector. By leveraging service expansion to build pathways into clinical and allied health professions and investing in on-site training and certification programs, SCH has the potential to cultivate a pipeline of skilled workers drawn from local residents who might otherwise have migrated outward in search of employment opportunities in healthcare.

[96] UCLA Health. U.S. facing critical hospital bed shortage by 2032. UCLA Health News & Insights. 2025.

[97] National Rural Health Association. Rural workforce recruitment and retention factors policy brief. 2025.

[98] Internal Revenue Service. SOI tax stats-data by geographic area. 2025.

[99] National Rural Health Association. Rural workforce recruitment and retention factors policy brief. 2025.



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Strategic Planning & Future Developments

Key community health issues identified through this assessment include:

- Obesity & Diabetes
- Heart Disease
- Poor self-reported health
- Poor health behaviors (alcohol and tobacco use, teen pregnancy, physical inactivity)
- Lack of prenatal care and labor & delivery services

Key barriers to health identified through this assessment include:

- Low median income
- Lack of access to transportation
- Lower health literacy
- Poor internet connectivity

Other factors impacting health outcomes within the community include:

- An aging rural population
- Geographic isolation from advanced medical facilities
- High percentage of adults insured through Medicare and projected growth in Medicare population



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In response to these health needs, barriers, and other community conditions, anticipated future needs within the market area include improved chronic care management, expanded hospital services to address pre-existing conditions, investment in maternal healthcare infrastructure, and community collaborations to address SDOH.

Improved Chronic Care Management

Chronic conditions and risk factors such as obesity, diabetes, and heart disease are highly prevalent within the market area. The development of strong chronic care management programs relies on access to preventive care, as well as cross-sector partnerships that address underlying drivers of health and barriers to receiving care. SCH primary care clinics currently offer family practice primary care services and are able to refer patients directly to community resources to address health related needs and barriers to care. Future developments in chronic care management may include improvements in SCH's care navigation and/or case management infrastructure to assist patients in offering coordinated referrals to available community resources with follow-up to help ensure connections are being made. As broadband connectivity advances across the market area, the addition of telehealth capabilities among SCH primary care providers would allow for remote monitoring of patient conditions, as well as reducing transportation as a barrier to receiving care in the rural community.

Expanded Hospital Services

The SCH market area is projected to continue aging, resulting in a growing number of Medicare beneficiaries and increased need for advanced hospital services, including both inpatient and surgical care. The aging population may also result in a need to diversify the hospital's payor mix to avoid over-reliance on Medicare billing.

Investment in Maternal Healthcare Infrastructure

Schuyler County and surrounding rural communities do not currently have a hospital equipped to provide labor and delivery services. SCH has identified the need to offer prenatal care services directly through the hospital and is working actively to develop the infrastructure to offer maternal health services. Future developments may also include the implementation of labor and delivery services to improve maternal health equity in the rural market area.

Community Collaborations to Address SDOH

Social Drivers of Health (SDOH), including socioeconomic, environmental, and health behaviors have a greater compound influence on community health outcomes than access to medical care alone. The development of collaborative community partnerships to address key barriers to care within the market area (e.g., poverty, transportation, health literacy, and internet access) will exponentially strengthen community health strategies that improve key health needs within the market area.





2026 Community Health Needs Assessment

Questions? Burrows Consulting is available to discuss next steps. We're here to support your expansion and growth!

elizabeth@burrowsconsulting.net
shelby@burrowsconsulting.net



www.burrowsconsulting.net

Section III. Alternatives

Attachment 13

Alternatives

Provide alternatives to the proposed project. The comparison shall address issues of cost, patient access, quality, and financial benefits in both the short term (within 1-3 years after project completion) and in the long term.

SDCMH previously engaged Stroudwater to conduct an extensive master plan for its facilities. In that master planning it became evident that the 70+-year-old hospital structure needed considerable improvements or even a replacement hospital. During the master planning process SDCMH considered several alternatives before selecting the proposed Project:

1. Build a Replacement Hospital on another Site.

The ideal solution would be to construct a new replacement hospital on a nearby site. This would allow a modern design and layout and would allow for more efficiencies and energy savings. The cost in the long run would likely be similar to eventually making all necessary improvement to the existing building.

Unfortunately, any change in location would mean that SDCMH would lose its designation as a Critical Access Hospital. Without the Critical Access status, ongoing operations at SDCMH would not be financially feasible and this alternative could not be pursued. Consequently, this alternative was not seriously priced out but would have been estimated to be \$55.7 million.

Cost: Approximately \$55.7 million.

2. Construct a Replacement Hospital on the Current Site

Because of the critical access hospital relocation prohibition, SDCMH considered trying to construct a replacement hospital on the current site. The present site is not large enough that there is a “green grass” location on site for a replacement hospital. Instead, a replacement hospital on site would have involved a complex arrangement of demolishing part of the hospital for construction of a portion of the new hospital while continuing operations in the remaining part. Then there would be multiple phases where the hospital would need to temporarily move operations to the new section, while the remaining old section was demolished to allow for building the second phase of the replacement hospital. SDCMH considered this alternative and reviewed preliminary cost estimates. However, preliminary design work showed that the complexities resulted in an estimate of \$74.3 million which could have been higher than a replacement hospital on a new site. This alternative was determined to be too expensive and to have serious operational challenges during the construction.

Cost: \$74.3 million.

3. Pursue a Project of Larger Scope

The Master Design Plan identified numerous needed improvements beyond the proposed Project and SDCMH considered other needed improvements. These included demolishing and rebuilding a wing of patient rooms and replacing the Emergency Department and inpatient facilities. Pricing out other desirable improvements yielded an estimated cost of approximately \$37 million (design and construction only). While these are improvements SDCMH would like to make, and hopes to eventually, it decided to prioritize replacement of the mechanical equipment and replacement of the surgery area.

Cost: Approximately \$32.4 million.

4. Pursue a Smaller Scope – Renovate existing space with no new addition

The Master Design Plan analyzed renovating existing space with no new construction. Most urgent is the need for renovation of the surgical space and needed infrastructure improvements. The current configuration is one operating room and one procedure room. The operating room dates to 1952 and is too small to meet current IDPH size requirements for new ORs. The small room does not allow for modern equipment and personnel needed today for many procedures. Orthopedic procedures are equipment intensive and most orthopedic procedures cannot be performed at the hospital.

To renovate the existing space while continuing operations would create considerable operational disruption. Most particularly, all surgical services would need to be discontinued for at least one year.

Cost: \$20.5 million.

5. Maintain Status Quo. Doing nothing has no initial capital cost. However, not replacing the mechanical systems is not an option. As detailed in Attachment 31, it is necessary to replace these systems to keep the hospital operational. Similarly, the 70+-year-old operating room need replacement. The rooms are also undersized for modern equipment and certain procedures, such as orthopedic procedures, cannot be performed.

Cost: \$0 initially, but costs for needed capital improvements are deferred rather than addressed.

6. Construct Proposed Project

After careful consideration of various alternatives, SDCMH selected the proposed Project as meeting the hospital's highest priorities within financial availability.

Cost: \$26,460,706

Project	Summary	Pros	Cons
Construct a Replacement Hospital on New Site	Construct a Replacement Hospital on a new nearby site. Cost: \$55,770,174	• Ideal from operations perspective • Modern more efficient design	• If Hospital relocates it loses it's Critical Access Designation • Replacement Hospital would be outside the central city
Construct a Replacement Hospital on the Current Site	Construct a new replacement hospital on current site. \$74,360,232	• Modern more efficient design • More energy efficient	• There is no open space at the current hospital. The hospital would need to acquire adjacent property it does not own or would need to demolish and construct new space in phases • More costly • Complexities and cost outweigh the benefits
Pursue a Project of Larger Scope (See included alternatives considered in Stroudwater report)	This would include the proposed project and construction of new Inpatient addition \$32,463,066	• A large project scope is desirable and would encompass areas that will need improvement in the future	• Would require the acquisition of adjacent property not owned by the hospital • The need to prioritize capital expenditures requires deferral of other improvements at this time
Pursue a smaller scope – Renovate existing space with no new construction	Cost: \$20,541,017	• Better meet current IDPH state standards for surgical space and would increase surgical space to allow for procedures such as orthopedics which are not currently possible	• Very disruptive to existing services and surgical program would need to be shut down for over 1 year • Continued investment in a 1952 building for surgery would not be prudent

Project	Summary	Pros	Cons
Status Quo – Do Nothing Now		• No initial cost • No initial operational disruption	• The proposed Project essentially maintains or replaces mechanical equipment and surgical space that has outlived its functional life and needs to be replaced. Doing nothing now would only defer needed improvements
Construct Proposed Project	Cost: \$26,460,706	• The proposed project is the best compromise in meeting priorities for capital improvement with financial limits • The additional ED space will establish one ED bay optimized for trauma situations	• Recognizes that some needed capital improvements are being deferred

Section IV. Project Scope, Utilization, and Unfinished/Shell Space

Attachment 14

Project Scope, Utilization and Unfinished/Shell Space

The Project is designed to meet all the state standards for size.

The Project has several components including (i) replacing aging infrastructure and mechanical equipment, (ii) removing the obsolete 1920 original building to allow for construction of a 12,645 sf South Addition (including Basement) to accommodate a new Surgery department and to (iii) replace the existing Laboratory. The Project also includes a 1,355 sf proposed East Addition to accommodate a new main entry and other renovations (clinical and non-clinical) to accommodate improved Imaging, Pharmacy, Emergency, Administrative and public areas. In addition, hazardous materials will be removed and areas without fire suppression will have fire suppression systems installed.

To make way for the proposed South addition, the outdated existing 1920 building that houses Pharmacy, Cashier, Clinic space and Administrative functions will be demolished. To compliment the new additions, renovations will be made to the Hospital's 1952 and 1978 additions.

The areas in the Hospital having an identified space standard in the Board's rules are the following: General Radiology, Mammography, Ultra-sound, CT Scan, Nuclear Medicine, Emergency Department, Surgical Operating Suite including Sterile Processing, Post-Anesthesia Recovery Phase I and Post-Anesthesia Recovery Phase II.

The amount of proposed space is necessary and not excessive. In the interests of efficiency and cost control, the new areas developed in this Project have all been designed to be smaller than the maximums allowed in the State's standards. The space needs for proposed additions and renovations incorporate the State's Hospital Licensing Act as well as developing healthcare standards and accessibility requirements of the Illinois Accessibility Code and ICC A117.1.

This Project does not include any unfinished shell space.

ATTACHMENT 14

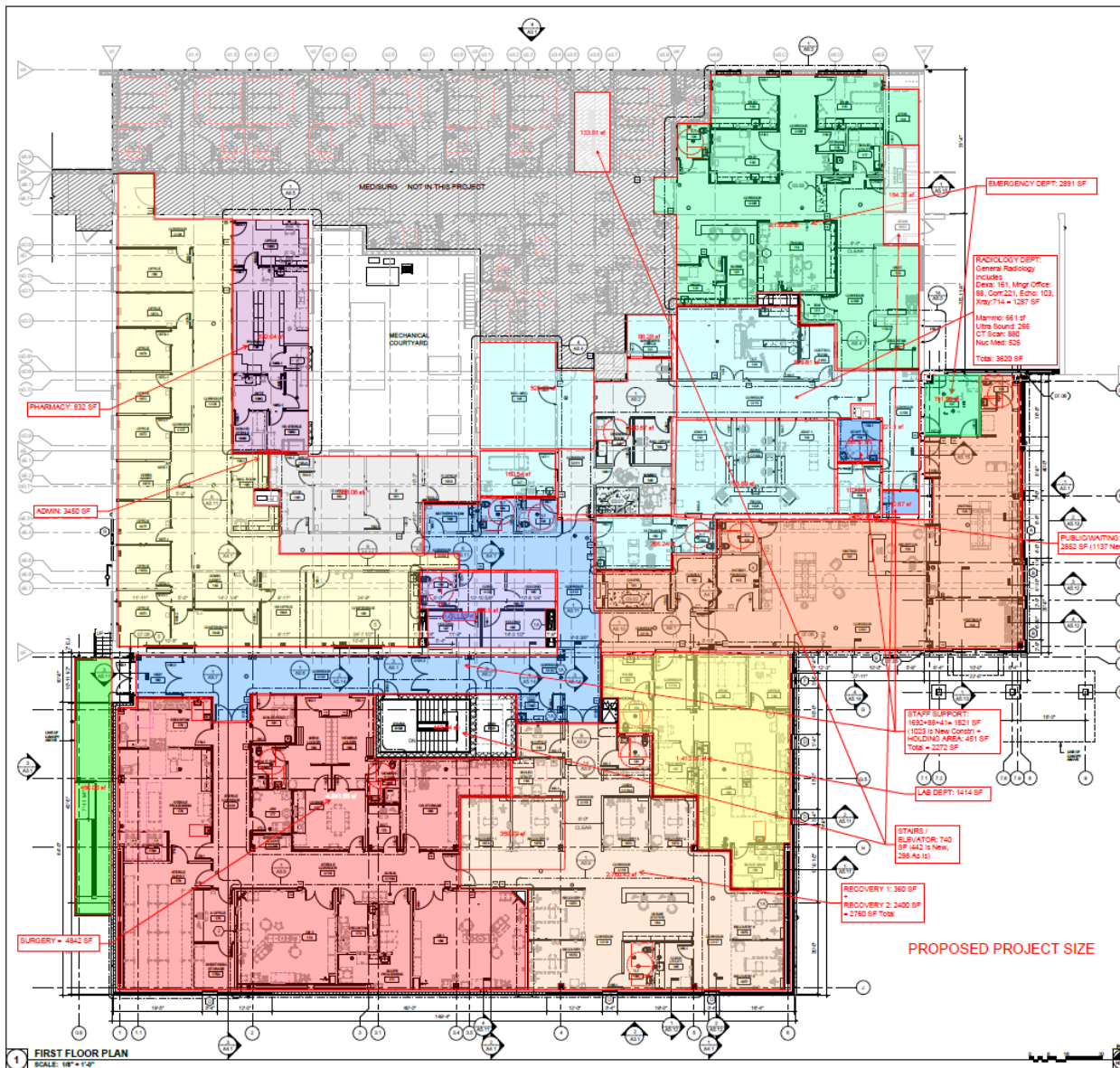
SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD (DGSF)	DIFFERENCE	MET STANDARD?
Clinical				
General Radiology	1287 dgsf	1300 dgsf/unit (2)	-1313 dgsf	Yes
Fluoroscopy (N/A) *	0 dgsf	1300 dgsf/unit	-1300 dgsf	Yes
Mammography	661 dgsf	900 dgsf/unit	-239 dgsf	Yes
Ultra-sound	266 dgsf	900 dgsf/unit	-634 dgsf	Yes
CT Scan	880 dgsf	1800 dgsf/unit	-920 dgsf	Yes
Nuclear Medicine	526 dgsf	1600 dgsf/unit	-1,074 dgsf	Yes
Emergency Department**	723 dgsf * 4 treatment station = 2,891 dgsf	900 dgsf/treatment station = 900 * 4 = 3,600 dgsf	-860 dgsf	Yes
Surgical Operating Suite (Class C). <i>Central Sterile Processing included.</i>	2,421 dgsf * 2 operating rooms = 4,842 dgsf	2750 dgsf/ operating room = 2750 * 2 = 5,500 dgsf	-709 dgsf	Yes
Post-Anesthesia Recovery Phase I ***	180 dgsf * 2 recovery I = 360 dgsf	180 dgsf/recovery station = 180 * 2 = 360 dgsf	0	Yes
Post-Anesthesia Recovery Phase II ****	400 dgsf * 6 recovery II = 2,400 dgsf	400 dgsf/ recovery station = 400 * 6 = 2,400 dgsf	0	Yes
Laboratory	1,414 dgsf	N/A	N/A	N/A
Pharmacy	832 dgsf	N/A	N/A	N/A
Non Clinical				
Public/ Waiting areas	2852 dgsf	N/A	N/A	N/A
Administration	3,450 dgsf	N/A	N/A	N/A
Staff Support/Holding Areas	2272 dgsf	N/A	N/A	N/A
Loading Dock	450 dgsf	N/A	N/A	N/A
Mechanical	16,756 dgsf	N/A	N/A	N/A
Stairs/Elevator	740 dgsf	N/A	N/A	N/A
Electrical/ IT	808 dgsf	N/A	N/A	N/A

* The one Fluoroscopy unit is located in the same General Radiation room as the current film X-Ray unit.

** Proposed Emergency Room modifications includes three examination rooms and one trauma room.

*** Proposed Post-Anesthesia Recovery Phase I includes two patient rooms.

**** Proposed Post-Anesthesia Recovery Phase II includes six patient rooms.



PLAN GENERAL NOTES

- SEEK TO LIFE SAFETY AND PROTECT LOCATION OF EXISTING PARTITIONS, SEPARATE INFORMATION AND PARTITION CODE. ALL INTERIOR PARTITIONS ARE TYPE 1 UNLESS OTHERWISE NOTED OR SHOWN.
- ALL DIMENSIONS ARE TO FACE OF STUDY OR CONCRETE UNLESS NOTED OTHERWISE.
- OPENING DIMENSIONS ARE TO FRAME FRAME. CONTRACTOR TO VERIFY ROUGH OPENING REQUIREMENTS.
- ALL WOOD IN CONTACT WITH CONCRETE SHALL BE PRESURE TREATED.
- ALL NEWWORK SHALL BE PLUMB, TRUE, AND LEVEL UNLESS OTHERWISE NOTED.
- EXISTING FIVE REINFORCED CONCRETE TO STRUCTURE BEING RETAINED PARTITIONS AND/OR EQUIPMENT, CHASIS, AND OTHER ITEMS THAT REMAIN IN PLACE SHALL BE PROTECTED BY PARTITION WALLS TO BE MAINTAINED AND/OR REINFORCED. SEE ALL SAFETY BRACKETS FOR FURTHER INFO AND SHOWN REINFORCEMENT INFORMATION.
- CONCRETE FLOOR MATERIALS SHALL MEET UNDER CENTER OF JOIST LEAF.
- FURNITURE IS SHOWN FOR REFERENCE ONLY AND IS NOT IN CONTRACT.
- EQUIPMENT IS SHOWN FOR REFERENCE AND IS FURNISHED BY OTHERS.

IDENTIFY PROJECT AREA THAT IS NOT INCLUDED IN THIS PROJECT RECORD

KEYNOTES (BY DIVISION) C-10

DIVISION	CONCRETE
101	CONCRETE SLAB WALL OF EXISTING BUILDING SHALL BE OPENED.
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1 FIRST FLOOR PLAN
SCALE: 1/8" = 1'-0"

Farnsworth GROUP
3301 W. WHITE OAK DR., SUITE 3000
SPRINGFIELD, ILLINOIS 62764
(312) 528-3662 / info@fng.com

OSHEA BUILDERS
www.oshea.com
Engineer / Architect / Surveyor / Designer

DD 541
NOT FOR CONSTRUCTION

Sarah D. Culbertson Memorial Hospital
SDCMH SURG ADD & RENO
228 S CONGRESS ST.
SPRINGFIELD, IL 62761

DATE: 01/06/2008
DESIGNED: BMM, DMH
DRAWN: TRW
REVIEWED: BMM

A1.1
PROJECT NO.: 02501295.001

Section IV. Project Services Utilization

Attachment 15

Appendix B, Project Services Utilization

1110.120 c) Project Size Utilization – For areas for which there are utilization standards as shown in Appendix B

Document that in the 2nd year of operation, the annual utilization of the service shall meet or exceed the utilization standards.

The State Standard for surgery is 1,500 hours per each operating room and each procedure room. SDCMH currently has one operating room and one procedure room. The proposed Project will replace the existing OR with two ORs instead of one OR and one procedure room.

Surgical Utilization

Like all other Critical Access Hospitals (CAH) in Illinois, SDCMH acknowledges that it does not presently have the volume to meet the state standard and that it similarly will not do so following project completion. As part of this CON process, SDCMH reviewed the utilization of the approximately 50 Critical Access Hospitals in Illinois. As the table and discussion in Attachment 31 shows, not a single CAH meets this standard in either 2023 or 2024⁵. We also note that HFSRB changed the format of the Hospital Profile Reports and the number or utilization of procedure rooms no longer appear on the Profile. Similarly, not a single CAH meets the bed utilization standard. In almost all cases, it is not even close. This review also showed that, with one exception, every CAH had a minimum of two ORs. Attachment 31 also addresses why the need for at least two ORs is essential to provide the critical access that is the mission of critical access hospitals.

UTILIZATION					
YEARS	DEPT./ SERVICE Surgery	HISTORICAL UTILIZATION Surgical Hours	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
2022		408		1,500 hours/OR	No
2023		639			No
2024		708			No
2031			1,141		No

⁵ For 2024, two CAHs show abnormal surgical utilization for surgical hours and there appear to be an aberration in the profile numbers reported.

Imaging Utilization

SDCMH currently has one CT scanner, one mammography machine, one fluoroscopy unit, one ultrasound unit, one contracted MRI, and two x-ray machines.⁶ There will be no change in the numbers of imaging equipment as a result of this Project. Because of the HFSRB practice of rounding up when there is only a single category of equipment, the imaging categories except general radiology would meet the Review Board's standard for utilization.

SDCMH plans to replace one of its two X-ray units as part of this Project. That unit is quite old and does not have digital capabilities. The state utilization standard is 8,000 X-rays per unit. Clinically it is important to have a second X-ray unit at the hospital regardless of utilization. X-ray units are essential for a hospital, particularly in emergency/trauma situations. X-ray units can occasionally be out of service, and it is important to have redundancy. If the one x-ray unit were to be out of service the hospital would need to go on bypass, and there is no close hospital alternative. For medical equipment, an X-ray unit is relatively inexpensive and worth the cost for patient care.

General Radiology/X-RAY					
YEARS	DEPT./ SERVICE General Radiology	HISTORICAL UTILIZATION X-rays	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
2022		3,885		8,000 / unit	No
2023		3,537			No
2024		3,480			No
2031			3,476		No

⁶ SDCMH acknowledges that some equipment and utilization numbers are incorrect on its prior AHQs and is undertaking to make corrections.

CMH Volumes		FY26 (March 2025 - Feb 2026)	FY27 (March 2026 - Feb 2027)	FY 28 (March 2027 - Feb 2028)	FY29 (March 2028 - Feb 2029)	FY30 (March 2029 - Feb 2030)	FY31(March 2030-2031)	Note
Cardiac Rehab		1446	1475	1504	1535	1565	1597	2%
Chemotherapy Treatments		622	634	647	660	673	687	2%
CT		2587	2639	2692	2745	2800	2856	2%
DEXA		214	218	223	227	232	236	2%/33% Mammo Population
Echocardiogram		440	449	458	467	476	486	2%
ED Visits		4286	4372	4459	4548	4639	4732	2%
GI Procedures		402	410	418	427	435	444	2%
Infusion Treatments		899	917	935	954	973	993	2%
Mammography		644	657	670	683	697	711	2%
MRI		358	365	372	380	388	395	2%
Nuclear Medicine		100	102	104	106	108	110	2%
Office Visits		16165	16488	16818	17154	17498	17847	2%
PET		90	95	96	98	100	102	30 Reg. Cancer Patients x 2 and 30 Begin Patient x1 /5%
Therapy Unit		12285	12531	12781	13037	13298	13564	2%
Stress Test		20	21	21	22	22	23	5%
OP Surgicalical Procedures		145	150	167	179	203	227	12% FY30 v FY31
Swing Bed Days		245	282	296	311	326	342	5%
Ultrasound		948	967	986	1006	1026	1047	2%
X-Ray		3148	3211	3275	3341	3407	3476	2%

ATTACHMENT 15

Surgeries		Average Procedure Time (Minutes)	Average Setup Time (Minutes)	Average Clean Up Time (Minutes)	Total Time (Minutes)	Procedures/ Surgeries FY30	Annual Procedure /Surgery Time (Minutes)	Annual Procedure /Surgery Time (Hours)	Procedures/ Surgeries FY31	Annual Procedure/ Surgery Time (Minutes)	Annual Procedure/Surgery Time (Hours)
Cataract Surgeries		20	15	30	65	30	1950	33	60	3900	65
ENT Surgeries		20	15	45	80	24	1920	32	26	2080	35
General Surgeries		45	30	45	120	42	5040	84	44	5280	88
GI Procedures		30	15	45	90	435	39150	653	444	39960	666
GYN Surgeries		30	30	45	105	12	1260	21	14	1470	25
Orthopedic Surgeries		60	45	45	150	12	1800	30	24	3600	60
Podiatry Surgeries		50	30	45	125	12	1500	25	14	1750	29
Urology Procedures		20	30	45	95	89	8455	141	91	8645	144
Vascular Surgeries		50	30	45	125	12	1500	25	14	1750	29
TOTAL								1043			1141

Annual Procedure Room Hours FY30	758
Annual Procedure Room Hours FY31	774
Annual Operating Room Hours FY30	285
Annual Operating Room Hours FY31	367

ATTACHMENT 15

Attachment 31

Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ Surgery - OR	1	2
☐ Surgery – Procedure	1	0
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
1APPEND DOCUMENTATION AS <u>ATTACHMENT 31</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Attachment 31

Criterion 1110.270(c)(2)

SDCMH believes it meets the criterion for modernization under 1110.270(c)(2) and addresses that criterion below.

A. Deteriorated Facilities

The Project has several components including (i) replacing aging infrastructure and mechanical equipment, (ii) removing the obsolete 1920 original building to allow for construction of a 12,645 sf South Addition (including Basement) to accommodate a new Surgery department and to (iii) replace the existing Laboratory. The Project also includes a 1,355 sf proposed East Addition to accommodate a new main entry and additional renovations (clinical and non-clinical) to accommodate improved Imaging, Pharmacy, Emergency, Administrative and public areas.

To make way for the proposed South addition, the outdated existing 1920 building that houses Pharmacy, Cashier, Clinic space and Administrative functions will be demolished. To compliment the new additions, the Hospital plans to renovate the 1952 and 1978 additions. These improvements including adding sprinklers and fire suppression and asbestos abatement throughout the 1952 and 1978 portions of the building.

Surgery Department

The present operating room was constructed as part of the 1952 addition and is too small to meet the current IDPH standards. This OR is insufficiently sized for the volume and complexity of surgical cases, particularly Orthopedic cases and lacks adequate space to accommodate increasing size of equipment and technology utilized. IDPH regulations specify a minimum of 360 sf clear of fixed cabinetry and with minimum dimension of 18 ft. IL Admin Code 250 .2440(i). The current OR meets neither the sf or dimension requirements and is grandfathered-in under the IDPH Hospital Licensing Code to maintain licensure. The Facilities Guideline Institute establishes hospital guidelines followed by most hospitals nationwide. The FGI standards state that new ORs should be between 400 and 600 sf, and at least 500 sf for orthopedic procedures. The current OR is less than 345 sf and does not meet current standards. With currently only a single OR, the existing department lacks redundancy and efficiency for set up/clean up between cases.

Although the new surgery department features orthopedic sized ORs and state-of-the-art PACU and support facilities, the total space allocation for the department has been designed to comply with the State size standards. The proposed design provides major improvements for the street to clean corridor functional flows and provides for improved Sterile Processing support and ADA compliance.

Laboratory

The current Laboratory department is very difficult to access by outpatients for Phlebotomy and has inadequate available space to accommodate current and future equipment needs. The proposed Laboratory is 45% larger than the existing so it can accommodate updated Laboratory equipment, functional support spaces and ADA compliance. The proposed location of the new department provides for convenient access to Phlebotomy near the main entrance for outpatients.

Pharmacy

The current Pharmacy department is currently located within the 1920 building which will be demolished. The proposed Pharmacy is 20% larger than the existing so it can provide the same functionality with some additional space to accommodate equipment and clearances.

Renovations and Modernization

The eastern portion of the existing 1952 building houses public toilet rooms, Outpatient Clinic functions and Waiting space which will be converted into reconfigured Waiting and Reception space, Consultation room, Chapel and Ultrasound space.

The western portion of the existing 1952 building houses Ultrasound, IT and Surgery department space. These areas will be repurposed to accommodate public toilets, expanded IT, Mail Room, Storage, Conference room, Administrative functions and Pharmacy. There will also be a dedicated entrance and waiting suite associated with Prison population use.

The northern portion of the 1978 addition will have former Laboratory space repurposed as expansion for the Emergency Department. Portions of the existing Imaging department will be relocated into portions of the 1952 addition to accommodate needed expansion for the Emergency Department and development of a new, properly sized CT Scan room.

Non-Clinical Areas

The Project includes improvements to the main entry/registration areas including a new entry canopy.

Administrative space is currently located within the 1920 building which will be demolished and relocated to the western portion of the 1952 building.

The Project includes the removal and replacement of the Hospital's existing elevator which is at end-of-life condition, is of inadequate size for freight/deliveries and is in an undesirable location. This original hydraulic elevator was constructed as part of the 1952 building and outdated electronics with almost obsolete repair parts and frequent hydraulic leaks.

The Project includes provision of an egress stair to provide access to the Basement expansion and replacing the existing non-code compliant stair. In addition, hazardous materials (primarily asbestos) will also be removed throughout the hospital.

Mechanical/Electrical/Plumbing

The Project includes replacement of existing HVAC equipment as follows:

Existing RTU 3 is a cooling-only unit installed in 2005 which doesn't meet current demand loads as it is severely undersized for area it serves (dietary & server room where increased heat loads diminish its effectiveness and efficiency).

Existing AHU # 7 condenser unit was installed in 2014 but is plagued by multiple ongoing refrigerant leaks and microchannel coil replacements. It serves Lab, Imaging, and Emergency departments but has unreliable compressor issues and often requires evaporator fan repairs.

Electrical

Thirteen electric panels need to have feeders, breakers and panels replaced. Most of these panels were installed in 1952 with old breakers/feeder wiring. These panels are functional but are so old that used replacement parts have to be purchased for repairs.

The Nurse Call system 1 needs to be upgraded for redundancy and UPS.

Plumbing/Medical Gas/Fire Protection

The Project includes replacement and/or addition of equipment as follows:

Domestic Water system: domestic water tank and associated piping is 25+ years old. There is currently no redundancy for hot water. Increased hot water demand will strain the current system. The existing water tank leaks periodically and requires repair.

Boiler system: the non-condensing natural gas boiler system was installed in 1998 has outlived its usable lifespan. The piping system has failing piping/valves/pumps and there is no redundant fuel source.

Sterilizers: the Sterile Processing area has Tuttenauer Sterilizers and supporting air compressor. Installed in 1998, it is unreliable with monthly breakdowns and is at end of usable life. Parts are difficult to source. Repair requires specialized technicians from a 3rd party company to complete work.

Medical Air: Medical Air pump as one is not currently available.

Fire sprinklering will be added throughout the hospital, including previously unprotected spaces in the Basement and main level. This was deemed appropriate after discussion with IDPH upon discovering existing code required fire separations and fireproofing protective coatings are incomplete or deteriorated in areas.

Photos showing hospital infrastructure in need of improvement and included in this Attachment 31.

B. Necessary Expansion

The applicable Review Board regulations relative to a Project such as this state that the Project must me one of the three provisions.

- c) *Service Modernization*
The applicant shall document that the proposed project meets one of the following:
 - 1) *Deteriorated Equipment or Facilities*
The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement.
Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.
 - 2) *Necessary Expansion*
The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand.
Documentation shall consist of, but is not limited to historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.
 - 3) *Utilization*
 - A) *Major Medical Equipment*
Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.
 - B) *Service or Facility*
Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

1110.270(c) (emphasis added)

As discussed above, this application documents that the Project meets the deteriorated facilities provisions in subsection (1) above. The Project replaces mechanical equipment servicing the hospital and adds fire suppression systems in areas in which the hospital currently lacks sprinklers. Importantly, by replacing the operating room and procedure room with two ORs that meet state standards and national guidelines satisfies the “Necessary Expansion” criterion.



Domestic water tank and associated piping – 25+ years old. No redundancy for hot water even after adding new patient room showers. Increased hot water demand will strain current setup. Tank leaks at times.



Non condensing boiler system.
Natural gas fuel. Installed in 1998.
Outlived its usable lifespan. Failing
piping/valves/pumps associated with
the piping system. No redundant fuel
source



Single O.R, built in 1952. Aged infrastructure, feels and looks dated. Humidity problems in summertime due to building envelope. Surgical and diagnostic equipment dated.



Tuttenauer Sterilizers and supporting air compressor. Installed in 1998. End of usable life. Unreliable. Monthly breakdowns. Parts hard to find and repair. Requires specialized technician from 3rd party company to complete work.



Original hydraulic elevator built with the 1952 building. Very dated electronics with almost obsolete repair parts. Frequent hydraulic leaks
Elevator car too small for freight/deliveries.



Dated electrical panel distribution with old breakers/feeder wiring. Most installed in 1952. Functional but parts are purchased used for repairs due to age.



RTU #3. Cooling only unit installed in 2005. Severely undersized for area it serves (dietary & Server room where increased heat loads diminish its effectiveness and efficiency.



AHU # 7 condenser unit. Installed in 2014. Plagued by multiple ongoing refrigerant leaks and microchannel coil replacements. Serves lab, imaging, E.R departments. Unreliable compressor issues and evaporator fan repairs.

Criterion 1110.270(c)(3)(B)

C. Utilization – Service or Facilities

SDCMH believes it meets the deteriorated facilities test and that it also meets the Necessary Expansion test. The Review Board regulations provide the utilization standards for key rooms do not apply when the Necessary Expansion provision is met. Because SDCMH believes it meets that test, it appears the utilization standards test is inapplicable. Nevertheless, we have analyzed this issue and provide the information below.

First, we believe that the two ORs are necessary. Two ORs will provide needed redundancy. One OR does not provide the efficiency required by the structure of today's physician outreach contracts. On days that SDCMH hosts outreach surgeons or other specialist providers, that provider evaluates / treats patients in a clinical office setting and performs surgical procedures. Efficiency is the key to allow outreach providers to perform the most amount of care and allow the outreach day to be financially viable for the hospital. Unlike large hospitals or systems, SDCMH employs no surgeons. Most surgeons do not live in Rushville and schedule days to come to our hospital to perform procedures. They want to be able to quickly move from one procedure in one OR to another procedure in a second OR, without waiting while an OR is cleaned and prepared. Requiring a surgeon to be idle while the one OR is prepared or cleaned is inefficient for both the surgeon and the hospital.

Like all other Critical Access Hospitals (CAH) in Illinois, SDCMH acknowledges that it does not presently have the volume to meet the state standard and that it similarly will not do so following project completion. As part of this CON process, SDCMH reviewed the utilization of the approximately 50 Critical Access Hospitals in Illinois. As the table and discussion in Attachment 31 shows, not a single CAH meets this standard in either 2023 or 2024⁷. Similarly, not a single CAH meets the bed utilization standard. In almost all cases, it is not even close. This review also showed that, with one exception, every CAH had a minimum of two ORs.

Also attached is a table showing the projected utilization following project completion. These numbers represent procedures for residents that presently must leave the area for care, and which could instead be performed in the new area by physicians choosing to perform procedures in the hospital.

⁷ For 2024, two CAHs show abnormal surgical utilization for surgical hours and there appear to be an aberration in the profile numbers reported.

CMH Volumes		FY26 (March 2025 - Feb 2026)	FY27 (March 2026 - Feb 2027)	FY 28 (March 2027 - Feb 2028)	FY29 (March 2028 - Feb 2029)	FY30 (March 2029 - Feb 2030)	FY31(March 2030-2031)	Note
Cardiac Rehab		1446	1475	1504	1535	1565	1597	2%
Chemotherapy Treatments		622	634	647	660	673	687	2%
CT		2587	2639	2692	2745	2800	2856	2%
DEXA		214	218	223	227	232	236	2%/33% Mammo Population
Echocardiogram		440	449	458	467	476	486	2%
ED Visits		4286	4372	4459	4548	4639	4732	2%
GI Procedures		402	410	418	427	435	444	2%
Infusion Treatments		899	917	935	954	973	993	2%
Mammography		644	657	670	683	697	711	2%
MRI		358	365	372	380	388	395	2%
Nuclear Medicine		100	102	104	106	108	110	2%
Office Visits		16165	16488	16818	17154	17498	17847	2%
PET		90	95	96	98	100	102	30 Reg. Cancer Patients x 2 and 30 Begin Patient x1 /5%
Therapy Unit		12285	12531	12781	13037	13298	13564	2%
Stress Test		20	21	21	22	22	23	5%
OP Surgicalical Procedures		145	150	167	179	203	227	12% FY30 v FY31
Swing Bed Days		245	282	296	311	326	342	5%
Ultrasound		948	967	986	1006	1026	1047	2%
X-Ray		3148	3211	3275	3341	3407	3476	2%

2024 - Illinois Critical Access Hospital Operating Rooms and Utilization

	City	Hospital	CON Bed Occupancy	ORs	Total Surgical Hours	% of State Standard	Meets Surgical Standard
1.	Aledo	Genesis Medical Center	17%	2	1,290	43%	No
2.	Benton	Franklin Hospital	29.2%	2	146	4.9%	No
3.	Carlinville	Carlinville Area Hospital	42.5%	2	899	30.0%	No
4.	Carrollton	Boyd Healthcare Services	14.5%	0	0		N/A
5.	Carthage	Memorial Hospital	48.2%	2	1,170	39.0%	No
6.	Chester	Memorial Hospital	18.1%	4	536	8.9%	No
7.	Clinton	Warner Hospital & Health Services	28.9%	3	2,662	59.2%	No
8.	Du Quoin	Marshall Browning Hospital	39.1%	2	341	11.4%	No
9.	Eldorado	Ferrell Hospital	39.3%	0	890		No
10.	Eureka	Carle Eureka Hospital	20.6%	2	366	12.2%	No
11.	Fairfield	Fairfield Memorial Hospital	119.5%	5	2,286	30.5%	No
12.	Flora	Clay County Hospital	12.4%	2	422	14.1%	No
13.	Galena	Midwest Medical Center	43.0%	2	10,237	341.2%	No
14.	Geneseo	Hammond-Henry Hospital	181.9%	0	1,467		No
15.	Gibson City	Gibson Area Hospital & Health Services	91.9%	7	4,839	46.1%	No
16.	Harvard	MercyHealth Hospital and Medical Center-Harvard	359.8%	2	1,112	37.1%	No
17.	Havana	Mason District Hospital	11.5%	1	30	2.0%	No
18.	Highland	St. Joseph's Hospital	79.2%	2	1,886	62.9%	No
19.	Hillsboro	Hillsboro Area Hospital Hillsboro Health	26.2%	2	527	17.6%	No
20.	Hoopeston	Carle Hoopeston Regional Health Center	34.6%	2	308	10.3%	No
21.	Hopedale	Hopedale Medical Complex	23.2%	17	1,956	7.7%	No
22.	Jacksonville	Jacksonville Memorial Hospital	19.8%	7	3,039	28.9%	No

	City	Hospital	CON Bed Occupancy	ORs	Total Surgical Hours	% of State Standard	Meets Surgical Standard
23.	Kewanee	OSF Healthcare Saint Luke Medical Center	20.0%	2	791	26.4%	No
24.	Lawrenceville	Lawrence County Memorial Hospital	26.5%	1	287	19.1%	No
25.	Lincoln	Lincoln Memorial Hospital	72.1%	3	659	14.6%	No
26.	Litchfield	St. Francis Hospital	36.8	2	2,109	70.3%	
27.	McLeansboro	Hamilton Memorial Hospital District	28.0%	2	25,342	844.7%	*
28.	Mendota	OSF Healthcare Saint Paul Medical Center	31.9%	2	920	30.7%	No
29.	Monmouth	OSF Healthcare Holy Family Medical Center	31.7%	2	1,774	59.1%	No
30.	Monticello	Kirby Medical Center	31.8%	0	921		
31.	Morrison	Morrison Community Hospital	30.9%	3	2,417	53.7%	No
32.	Mt. Carmel	Wabash General Hospital	32.3%	0	3,234		No
33.	Nashville	Washington County Hospital	67.7%	1	22	1.5%	No
34.	Olney	Carle Richland Memorial* Hospital	93.5%	4	2,329	38.8%	No
35.	Pana	Pana Community Hospital	36.9%	2	472	15.7%	No
36.	Paris	Horizon Health	36.5%	2	3,873	129.1% *	No
37.	Pinckneyville	Pinckneyville Community Hospital District	45.4%	2	402	13.4%	No
38.	Pittsfield	Illini Community Hospital	19.8%	2	138	4.6%	No
39.	Princeton	OSF Healthcare Saint Clare Medical Center	29.0%	3	1,349	30.0%	No
40.	Red Bud	Red Bud Regional Hospital	53.9%	2	658	21.9%	No
41.	Robinson	Crawford Memorial Hospital	35.8%	3	2,633	58.5%	No
42.	Rochelle	Rochelle Community Hospital	24.0%	2	809	27.0%	No
43.	Rushville **	Sarah D. Culbertson	9.8%	5	47	.63%	No

ATTACHMENT 31

	City	Hospital	CON Bed Occupancy	ORs	Total Surgical Hours	% of State Standard	Meets Surgical Standard
		Memorial Hospital					
44.	Salem	Salem Township Hospital	20.3%	2	0		N/A
45.	Sandwich	Northwestern Medicine Valley West Hospital	45.8%	3	334	7.4%	No
46.	Staunton	Community Hospital	21.4%	0	0		N/A
47.	Taylorville	Taylorville Memorial Hospital	66.9%	3	2,299	51.1%	No
48.	Vandalia	Sarah Bush Lincoln Fayette County Hospital	151.2%	3	710	15.8%	No
49.	Watseka	Iroquois Memorial Hospital	13.5%	0	934		No

*Review of the Facility Profile appear to show aberrations in reporting.

**Information reported on SDCMH AHQ will need to be corrected.

Sources: Illinois Critical Access Hospital Network as to CAH hospitals and 2024 HFSRB Hospital Profiles as to utilization.

2023 - Illinois Critical Access Hospital Operating Rooms and Utilization

	City	Hospital	CON Bed Occupancy	ORs	Procedure Rooms	Total Surgical Hours	% of State Standard	Meets Surgical Standard
1.	Aledo	Genesis Medical Center	18.9%	2	2	1,950	65	No
2.	Benton	Franklin Hospital	18.7%	2	2	105	3.5	No
3.	Carlinville	Carlinville Area Hospital	2.7%	2	0	906	30.2	No
4.	Carrollton	Boyd Healthcare Services	4.3%	0	0	0	0	NA
5.	Carthage	Memorial Hospital	40.6%	2	0	1,084	36.1	No
6.	Chester	Memorial Hospital	9.7%	4	2	534	8.9	No
7.	Clinton	Warner Hospital & Health Services	6.4%	2	2	176	5.9	No
8.	DuQuoin	Marshall Browning Hospital	14.4%	2	0	193	6.4	No
9.	Eldorado	Ferrell Hospital	32.7%	4	1	1,238	20.6	No
10.	Eureka	Carle Eureka Hospital	0.7%	2	0	402	13.4	No
11.	Fairfield	Fairfield Memorial Hospital	39.9%	5	0	3,204	42.72	No
12.	Flora	Clay County Hospital	20.0%	2	0	658	21.9	No
13.	Galena	Midwest Medical Center	26.4%	2	0	5,196	1.732	No
14.	Geneseo	Hammond-Henry Hospital	7.1%	3	1	894	19.86	No
15.	Gibson City	Gibson Area Hospital & Health Services	52.9%	7	0	4,271	40.68	No
16.	Harvard	MercyHealth Hospital and Medical Center-Harvard	55.7%	2	1	1,706	56.9	No
17.	Havana	Mason District Hospital	9.1%	1	1	333	22.2	No
18.	Highland	St. Joseph's Hospital	42.8%	2	1	1,600	53.3	No
19.	Hillsboro	Hillsboro Area Hospital Hillsboro Health	14.5	2	0	439	14.6	No
20.	Hoopeston	Carle Hoopeston Regional Health Center	26.1%	2	0	302	10.07	No
21.	Hopedale	Hopedale Medical Complex	14.0%	3	2	1,426	31.7	No
22.	Jacksonville	Jacksonville Memorial Hospital	23.6%	7	2	3,387	32.25	No

	City	Hospital	CON Bed Occupancy	ORs	Procedure Rooms	Total Surgical Hours	% of State Standard	Meets Surgical Standard
23.	Kewanee	OSF Healthcare Saint Luke Medical Center	15.1%	2	1	446	14.9	No
24.	Lawrenceville	Lawrence County Memorial Hospital	17.8%	0	0	282	0	No
25.	Lincoln	Lincoln Memorial Hospital	26.3%	3	0	846	18.8	No
26.	Litchfield	St. Francis Hospital	43.7	2	0	1,425	47.5	No
27.	McLeansboro	Hamilton Memorial Hospital District	29.4%	2	0	14,955	*	*
28.	Mendota	OSF Healthcare Saint Paul Medical Center	30.2%	2	1	634	21.1	No
29.	Monmouth	OSF Healthcare Holy Family Medical Center	14.7%	2	0	1,180	39.3	No
30.	Monticello	Kirby Medical Center	18.3%	0	0	1,046	0	No
31.	Morrison	Morrison Community Hospital	23.9%	3	6	2,451	54.5	No
32.	Mt. Carmel	Wabash General Hospital	27.0%	0	0	3,005	0	No
33.	Nashville	Washington County Hospital	2.8%	1	1	10	.67	No
34.	Olney	Carle Richland Memorial* Hospital	16.7%	4	1	1,609	26.8	No
35.	Pana	Pana Community Hospital	8.2%	2	0	758	25.3	No
36.	Paris	Horizon Health	45.1%	2	1	2,664	88.8	No
37.	Pinckneyville	Pinckneyville Community Hospital District	16.0%	2	0	288	9.6	No
38.	Pittsfield	Illini Community Hospital	30.5%	2	1	300	1.0	No
39.	Princeton	OSF Healthcare Saint Clare Medical Center	24.3%	3	2	1,035	23.10	No
40.	Red Bud	Red Bud Regional Hospital	25.4%	2	1	404	13.5	No
41.	Robinson	Crawford Memorial Hospital	27.9%	3	2	2,513	55.8	No
42.	Rochelle	Rochelle Community Hospital	39.5%	4	2	475	7.9	No
43.	Rushville **	Sara D. Culbertson Memorial	7.4%	3	1	26	.58	No

	City	Hospital	CON Bed Occupancy	ORs	Procedure Rooms	Total Surgical Hours	% of State Standard	Meets Surgical Standard
		Hospital						
44.	Salem	Salem Township Hospital	40.3%	2	0	66,701	*	*
45.	Sandwich	Northwestern Medicine Valley West Hospital	35.5%	3	1	334	7.4	No
46.	Staunton	Community Hospital	7.3%	0	0	0	0	N/A
47.	Taylorville	Taylorville Memorial Hospital	19.7%	3	0	2,001	44.5	No
48.	Vandalia	Sarah Bush Lincoln Fayette County Hospital	30.5%	3	3	818	18.2	No
49.	Watseka	Iroquois Memorial Hospital	17.7%	0	0	863	0	No

*Review of the Facility Profile appear to show aberrations in reporting.

**Information reported on SDCMH AHQ will need to be corrected.

Sources: Illinois Critical Access Hospital Network as to CAH hospitals and 2023 HFSRB Hospital Profiles as to utilization.

Section VII. 1120.120 Availability of Funds

Attachment 34

Audited Financial Statements for years 2022, 2023, and 2024 are attached as a separate Appendix and show the availability of funds for the portion of the Project cost to be paid for with cash.

The debt portion of the Project will be financed by local banks and secured by Certificates of Deposit held at the banks. The letters show that the loans are pre-approved.

Section VIII. 1120.130 – Financial Viability

Attachment 35

The Financial Viability Waiver does not apply, and financial ratios are attached.

An analysis of the ratios show that SDCMH meets all state standards for Financial Ratios.

Financial Viability Standards	
Current Ratio:	10.11
Net Margin Percentage:	9.64
Long-Term Debt to Capitalization:	28.04
Projected Debt Service Coverage:	3.95
Days Cash-on-Hand:	644.79
Cushion Ratio:	32.54
Assumptions	
Projected Project Cost:	26,460,706
Depreciation Term (Years):	25
Annual Straight Line Depreciation:	1,058,428
Loan Principal:	20,000,000
Annual Interest Rate:	2%
Term (Years):	15

Financial Viability Standards					
Current Ratio:	10.11				Projected Project Cost: 26,460,706
Net Margin Percentage:	9.64				Depreciation Term (Years): 25
Long-Term Debt to Capitalization:	28.04	(current = 0)	*assuming loan principal=\$20,000,000, term=15 year, interest rate=2%		Annual Straight Line Depreciation: 1,058,428
Projected Debt Service Coverage:	3.95				Quoted Loan Principal: 20,000,000
Days Cash-on-Hand:	644.79				Quoted Annual Interest Rate: 2%
Cushion Ratio:	32.54				Quoted Term (Years): 15
Current Ratio = Current Assets / Current Liabilities					
			Current		
	Current Assets:		34,985,122		
	Current Liabilities:		3,460,871		
			10.11		
Net Margin Percentage = (Net Income/Net Operating Revenues) x 100					
			Current		
	Net Income:		2,425,757		
	Net Operating Revenues:		25,153,308		
			9.64		
Long-Term Debt to Capitalization = (Long Term Debt/(Long Term Debt + Net Assets)) x 100					
			Projected		
	Long-Term Debt:		20,000,000		
	Net Assets:		51,337,768		
			28.04		
Projected Debt Service Coverage = Net Income + (Depreciation + Interest + Amortization)/Principal Payments + Interest Expense for the Year of Maximum Debt Service after Project Completion					
			Annualized		
	Net Income:		2,910,908		
	Depreciation:		1,871,066		
	Interest:		1,314,442		
	Amortization:		-		
	Principal Payments (year 4):		1,226,328		
	Interest Expense (year 4):		318,093		
			3.95		
Days-Cash-on-Hand = (Cash + Investments + Board Designated Funds)/(Operating Expense - Depreciation Expense)/365					
			Annualized		
	Cash:		36,610,549		
	Investments:		20,000		
	Board Designated Funds:		13,629,092		
	Operating Expense:		29,263,218		
	Depreciation Expense:		812,638		
			644.79		
Cushion Ratio = (Cash + Investments + Board Designated Funds)/(Principal Payments + Interest Expense) for the year of max debt service after project completion					
			Annualized		
	Cash:		36,610,549		
	Investments:		20,000		
	Board Designated Funds:		13,629,092		
	Principal Payment:		1,226,328		
	Interest Expense:		318,093		
			32.54		

Attachment 36

Financial Viability Ratios are attached which appear to show that the Applicant meets all states standards.

Section IX. 1120.140 - Economic Feasibility

Attachment 37

Economic Feasibility

A. Reasonableness of Financing Arrangements.

Letters attesting to reasonableness of the financing arrangements are attached.

B. Conditions of Debt Financing.

The Project is being financed by cash on hand and debt financing. A letter attesting to conditions of debt financing is attached.

C. Reasonableness of Project and Related Costs.

The Project meets all the State Standards for Project Costs except the New Construction standard. O'Shea Builders will be constructing the Project pursuant to a Guaranteed Maximum Price (GMP) construction contract. Attached is an analysis from O'Shea Builders addressing factors as reasons for the proposed construction cost.



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Fax: 217-322-2546
cmhospital.com

March 3, 2026

Mr. John Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Sarah D. Culbertson Memorial Hospital Project
Reasonableness of Financing Arrangements 1120.140(a)(1)

Dear Mr. Kniery:

Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital is undertaking a project to expand and modernize its surgical services and make other mechanical and infrastructure improvements. We anticipate that the total estimated project costs will be funded in part by borrowing because:

- A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
- B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital further attests that the conditions of debt financing are reasonable in that the selected form of debt financing for the Project will be the lowest net cost available.

Schuyler County Hospital District
d/b/a Sarah D. Culbertson Memorial Hospital

Name: Tamra Gadberry
Title: Chief Financial Officer

Notarization:
Subscribed and sworn before me
this 3rd day of March, 2026.

Signature of Notary Public

Culbertson As The Choice Hospital

ATTACHMENT 37



Culbertson Memorial Hospital
238 S. Congress Street
Rushville, IL 62681

RE: Financing for Proposed Facility Project

To whom it may concern:

Beardstown Savings, s.b., is pleased to provide this pre-approval of credit terms to Culbertson Memorial Hospital for their proposed facility project. This proposal is a further demonstration of the strong, mutually beneficial relationship between the two entities that has developed over the years.

Due to the nature of the type of credit terms being proposed, below is a summary of the loan proposal and conditions associated with it. Our commitment to this loan proposal is subject to full and satisfactory underwriting and appropriate due diligence completed by Beardstown Savings. The following terms and conditions apply:

- **Collateral:** Existing Certificate of Deposits located at Beardstown Savings
- **Credit Limit:** Not to exceed 95% of the total value of the collateral pledged
- **Credit Structure:** One (1) – Five (5) year balloon note with amortization options of 10, 15, 20, or 30 years; Payments can be made monthly, quarterly, or semi-annually
- **Rate:** The rate of the loan will be 200bps higher than the Certificates of Deposit's rates that are being pledged for collateral
- **Transaction Costs:** All transaction and loan origination costs will be the responsibility of the borrower. Lender fees associated with the transaction will be determined at the time of final approval.
- **Repayment Plan:** On demand, but if no demand is made, the borrower will have the option of an amortization schedule not to exceed 30 years or 360 monthly payments. Amount the regular payment will depend on the term and payment frequency selected by the borrower.
- **Prepayment Penalty:** No prepayment penalty will apply to this loan.
- **Financial Reporting Covenants:** CPA and Board approved audited financial statements are to be submitted within 120 days following the end of the fiscal year.



301 State Street
P.O. Box 380
Beardstown, Illinois 62618
www.beardstownsavings.com
(217) 323-1400



Final terms of the loan are subject to final approval from Beardstown Savings Board of Directors. Please contact me to answer any questions or concerns you may have regarding this letter or loan proposal. We look forward to serving Culbertson Memorial Hospital throughout this project and for years to come.

Sincerely,



Rich Eckert
President & CEO
Beardstown Savings, s.b.
(217) 323-1400
reckert@beardstownsavings.com



February 23, 2026

Sarah D. Culbertson Memorial Hospital
Gregg Snyder, Executive Director
238 S Congress
Rushville, IL 62681

Dear Gregg,

Based on the conversations that we have had and with the information that you have provided, it is a pleasure to notify you that Clock Tower Community Bank has pre-qualified SDCMH for a commercial loan to make renovations and improvements to the hospital facilities. This pre-qualification is subject to receipt and review of the following items.

- Requested financials
- Subject to final underwriting approval
- Additional requirements as applicable

The basic terms of this loan are as follows:

- **Credit Limit:** Approximately \$4,815,000
- **Transaction Costs and Fees:** Not to exceed \$2,500
- **Interest Rate:** 2.00% above the associated interest rate to your Clock Tower Community Bank certificate of deposits, which will be utilized as collateral

This pre-qualification is issued in reliance upon the truth and accuracy of all financial information and other representations of facts contained in your application and supporting documentation or in any way furnished to us by you or on your behalf. All documentation may not have been received / verified in the rendering of this opinion. In the event of any change in your credit status, income, reserves, or collateral, Clock Tower Community Bank reserves the right to modify or withdraw this pre-qualification without any liability for doing so.

Thank you for choosing Clock Tower Community Bank for your commercial mortgage needs. If you have any questions, please, contact me at (217) 322-3432 or mike.clemens@mortonbank.com.

Sincerely,

Michael A. Clemens
Senior Community Banker

102 North Congress Street | Rushville, Illinois 62681 | 217.322.4387
hometownbanks.com



ATTACHMENT 37



RushvilleStateBank.com

February 19, 2026

Illinois Health Facilities and Services Review Board
525 W Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Schuyler County Hospital District dba Culbertson Memorial Hospital

To Whom It May Concern:

Rushville State Bank is pleased to provide this Letter of Commitment and indication of financing terms for consideration of the Schuyler County Hospital District. We look forward to continuing our relationship with Culbertson Memorial Hospital allowing them to expand healthcare services to residents of Rushville, IL and surrounding communities.

The following is a brief description of our terms and conditions for the proposed transaction and is intended for discussion only. Lender's commitment regarding this proposal and indication of credit terms and conditions is specifically subject to satisfactory underwriting, due diligence, and approval of Lender.

Project: Replacement and renovation of the original hospital building to provide for updated surgical and laboratory services with an estimated cost of \$22,425,000.

Loan Amount: Rushville State Bank loan amount will be approximately \$5,000,000 or the amount on deposit in Certificates of Deposit, whichever is less.

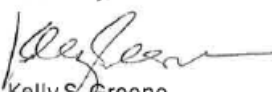
Collateral: Schuyler County Hospital District Certificates of Deposit with Rushville State Bank, projected at approximately \$5,000,000 in total.

Interest Rate: Rate will be set at 2.00% over the Certificate of Deposit Interest Rate.

Loan Terms: Original and subsequent loan terms set to match term of Certificate of Deposit. Total term to be approximately 180 months, payment frequency to be determined.

Please contact me to discuss additional questions or details regarding this project.

Sincerely,


Kelly S. Greene
President & CFO

100 E. Lafayette Street • P.O. Box 50 • Rushville, IL 62681-0050 • (217) 322-3323

NMLS# 643820  **FDIC** 

ATTACHMENT 37



February 27, 2026

Illinois Health Facilities and Services Review Board
525 W. Jefferson (2nd Floor)
Springfield, IL 62761

RE: Schuyler County Hospital District

To Whom It May Concern:

West Central Bank (WCB) is pleased to provide this proposal and indication of credit terms and conditions for the consideration of Schuyler County Hospital District (SCHD). We look forward to expanding our relationship with SCHD and assisting in its service to residents of Schuyler County.

Summarized below are the credit terms WCB is offering to SCHD.

- Collateral: Existing Certificates of Deposit. Certificates will be rewritten to all have the same maturity date.
- Credit Limit: Not to exceed 95% of the total value of the collateral pledged
- Credit Structure: One (1) - Five (5) year balloon note with amortization options of 10, 15, 20, or 30 years; Payments can be made monthly, quarterly, or semi-annually
- Rate: The rate of the loan will be 200bps higher than the Certificate of Deposits' rates that are being pledged for collateral. This rate will be variable and will adjust when the Certificates' rates change.
- Transaction Costs: All transaction and loan origination costs will be the responsibility of the borrower. Lender fees associated with the transaction will be determined at the time of final approval.
- Repayment Plan: On demand, but if no demand is made, the borrower will have the option of an amortization schedule not to exceed 30 years or 360 monthly payments. Amount of the regular payment will depend on the term and payment frequency selected by the borrower.
- Prepayment Penalty: No prepayment penalty will apply to this loan.
- Financial Reporting Covenants: CPA and Board approved audited financial statements are to be submitted within 120 days following the end of the fiscal year.

Please contact me with any questions you have regarding WCB's proposed terms. We appreciate your business and look forward to working with you on this venture.

Sincerely,

Emily Leonhard

Executive Vice President & Chief Credit Officer

400 E. Buchanan • P.O. Box 467
Ashland, IL 62612
(217) 476-3325

122 S. State Street • P.O. Box 470
Beardstown, IL 62618
(217) 323-4500

815 W. Clinton • P.O. Box 407
Rushville, IL 62681
(217) 322-4010

3600 Wabash Ave
Springfield, IL 62711
(217) 726-9600

ATTACHMENT 37



March 5, 2026

Schuyler County Hospital District d/b/a Sarah D. Culbertson Memorial Hospital
Surgery Addition and Renovations

Upon review of the current Project design we find the Project exceeds State Standards for Project Costs related to New Construction and Modernization. Following are examples of the circumstances and existing facility conditions that contribute to the increased costs:

The original 1920's era portion of the hospital building will be demolished to make space for the new Surgery, Recovery and Lab addition with partial basement. The footprint of the addition is approximately 6650 gsf larger than the existing space and will require additional fill and earthwork to bring this new floor slab up to a grade that matches the existing building. Additionally, the portion of the building exposed when demolition is complete will require temporary weather enclosure and safety measures while the new utilities, foundations and other infrastructure are underway.

Because the hospital has little space to temporarily relocate services, there are additional costs associated with keeping departments operational through building temporary containment of work zones while working through four (4) phases of construction, extending the schedule to 108 weeks.

Approximately 26,450 gsf of this project not currently protected by a fire sprinkler system will be retrofitted for full building coverage. This includes work in existing spaces not identified for modernization.

Replacing boilers, water heaters, condensing units and other building systems equipment into the existing building while keeping departments operational will require temporary measures to ensure limited interruptions.

This rural community location adds distance for resources, manpower and trucking. Most qualified bidders will come from Springfield, Quincy, Galesburg and Peoria or further. These cities are 57 to 73 miles away, respectively.

O'Shea Builders will be constructing the Project pursuant to a Guaranteed Maximum Price (GMP) construction contract based on competitive bids procured through advertising. Though this further ensures obtaining the best value for the hospital, we recognize market inflation and regional cost escalation, including impact of tariffs on supplies and construction materials also contributes to increased costs.

O'Shea Builders, Inc.

Tim Hickey
Preconstruction Manager

A handwritten signature in black ink, appearing to read 'Tim Hickey', is placed over the printed name.

BORN TO BUILD

osheabuilders.com

Attachment 37

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That is:			
Department	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
Emergency Dept	\$ 1,653,652	2,061	2,891	0	2,891		
Surgery	\$ 3,650,779	3,673	4,842	4,842	0		3,673
Radiology	\$ 1,875,160	2,841	3,620	0	3,620		
Pharmacy	\$ 455,936	863	832	0	832		31
Lab	\$ 955,864	962	1,414	1,414	0		962
Post Anesthesia Recovery	\$ 1,904,400	1,298	2,760	2,760	0		1,298
Contingency	\$ 749,239						
Clinical subtotal	\$ 11,245,030	11,698	16,359	9,016	7,343	0	5,964
NON-CLINICAL							
Public / Waiting / Chapel	\$ 1,965,443	2,144	2,852	1,137	1,715		
Administration	\$ 2,090,639	2,934	3,450	0	3,450		
Staff Support / Holding	\$ 1,503,220	1,960	2,272	1,023	1,249		
Loading dock / canopies	\$ 417,150	900	450	450	0		450
Mechanical / Basement	\$ 2,052,260	18,288	16,756	1,500	2,096	13,160	1,532
Stairs / Elevator	\$ 365,092	467	740	442	0	298	
IT / Electrical	\$ 467,832	397	808	0	808		
Contingency	\$ 638,241						
Non-clinical subtotal	\$ 9,499,877	27,090	27,328	4,552	9,318	13,458	1,982
TOTAL	\$ 20,744,907	38,788	43,687	13,568	16,661	13,458	7,946

ATTACHMENT 37

D. Project Operating Costs.

Estimated Costs, Procedures, and Cost per Patient Day

Projected Direct Operating Expenses – 2 years after		
Project Completion – Year 2030		
Total Operating Cost		\$1,474,470
Procedures		1,141
Direct Cost per Procedure		\$1,292

E. Total Effect of Project on Capital Costs.

		Projected FY 2031
Equivalent Patient Day		534
Total Project Capital Cost		\$26,460,706
Useful Life		25
Total Annual Depreciation		\$1,058,428
Depreciation cost per Equivalent Patient Day		\$1,982

Attachment 38

Section X. Safety Net Impact Statement

The proposed Project is classified as “non-substantive” under the Review Board’s rules. Consequently, Safety Net Impact statements are not applicable.

Section X. Charity Care

Attachment 39

Shown below is the amount of charity care provided by Schuyler County District Hospital d/b/a Sarah D. Culbertson Memorial Hospital (“SDCMH”)

CHARITY CARE			
	FY22	FY23	FY24
Net Patient Revenue	\$21,129,642	\$27,065,416	\$26,720,474
Amount of Charity Care (charges)	29,180	8,910	30,587
Cost of Charity Care	\$13,060	\$4,212	\$14,819
Ratio of Charity Care Cost to Net Patient Revenue	.06%	.02%	.06%