2025

Community Health Needs Assessment

OSF SAINT KATHARINE MEDICAL CENTER

Lee County

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EXECUTIVE SUMMARY

The Lee County Community Health Needs Assessment is a collaborative undertaking by OSF Saint Katharine Medical Center to highlight the health needs and well-being of Lee County residents. This assessment, with the help of collaborative community partners, has identified numerous health issues impacting individuals and families in the Lee County region. Prevalent themes include demographic composition, disease predictors and prevalence, leading causes of mortality, accessibility to health services, and healthy behaviors.

The results of this study can inform strategic decision-making, directly addressing the community's health needs. It was designed to assess issues and trends affecting the communities served by the collaborative and to understand the perceptions of targeted stakeholder groups.

This study includes a detailed analysis of secondary data to assess the community's health status. Information was collected from numerous secondary sources, both publicly and privately available data. Additionally, primary data were collected for the general population and the at-risk or economically disadvantaged population. Areas of investigation included perceptions of the community health issues, unhealthy behaviors, issues with quality of life, healthy behaviors and access to medical care, dental care, prescription medication, and mental-health counseling. Social drivers of health were also analyzed to understand why certain population segments responded differently.

Ultimately, the collaborative team identified and prioritized the most important health-related issues in the Lee County region. They considered health needs based on: (1) magnitude of the issue (i.e., what percentage of the population was impacted by the issue); (2) severity of the issue in terms of its relationship with morbidities and mortalities; and (3) potential impact through collaboration. Using a modified version of the Hanlon Method, TWO significant health needs were identified and determined to have equal priority:

- **Behavioral Health – Mental Health**
- **Access to Healthcare**

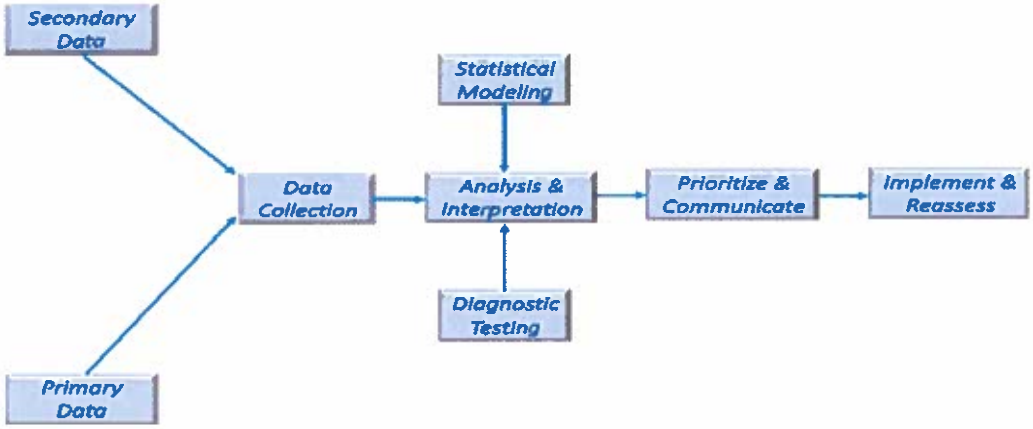
I. INTRODUCTION

Background

The Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010, introduced new requirements for tax-exempt charitable hospital organizations. These organizations must conduct community health needs assessments and adopt implementation strategies to address the community health needs identified through these assessments. This community health needs assessment (CHNA) includes input from specific individuals who represent the broad interests of the community served by OSF Saint Katharine Medical Center, including those with special knowledge of or expertise in public health. For this study, a community health needs assessment is defined as a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, create a plan, and act upon unmet community health needs. Results from this assessment will be made widely available to the public. This CHNA Report was approved by the OSF HealthCare System's Board of Directors on September 29, 2025.

The structure of the CHNA is based on standards used by the Internal Revenue Service to develop Schedule H, Form 990, designated solely for tax-exempt charitable hospital organizations. The fundamental areas of the community health needs assessment are illustrated below (Figure 1).

Figure 1



Collaborative Team and Community Engagement

To engage the entire community in the CHNA process, a collaborative team of health-professional experts and key community advocates was formed. Members of the team were carefully selected to ensure representation of the broad interests of the community. Specifically, team members included representatives from OSF Saint Katharine Medical Center, the Lee County Health Department, and administrators from key community partner organizations. Note that the collaborative team provided input for all sections of the CHNA. Individuals, affiliations, titles, and expertise can be found in APPENDIX

1. MEMBERS OF COLLABORATIVE TEAM. Engagement occurred throughout the process, resulting in shared ownership of the assessment. The entire collaborative team met in the second and third quarters of 2025. Additionally, numerous meetings were held between the facilitators and specific individuals during the process.

Definition of the Community

To determine the geographic boundaries for OSF Saint Katharine Medical Center, analyses were completed to identify what percentage of inpatient and outpatient activity was represented by Lee County. Data show that Lee County alone represents 68% of all patients for the hospital.

In addition to defining the community by geographic boundaries, this study targets the at-risk population as an area of potential opportunity to improve the health of the community. The at-risk population was defined as those individuals eligible to receive Medicaid based on the State of Illinois guidelines using household size and income level.

Purpose of the Community Health Needs Assessment

In the initial meeting, the collaborative team defined the purpose of this study. This study aims to equip healthcare organizations, such as hospitals, clinics and health departments, with the essential information needed to develop strategic plans for program design, access, and delivery.

The results of this study will enable healthcare organizations to efficiently allocate limited resources and better manage high-priority challenges. By working together, hospitals, clinics, agencies and health departments will leverage this CHNA to enhance health-care quality in Lee County. When feasible, data are assessed longitudinally to identify trends and patterns by comparing and benchmarking them against State of Illinois averages.

Community Feedback from Previous Assessments

The prior Katherine Shaw Bethea (KSB) Hospital 2022 CHNA was widely shared with the community after the OSF acquisition to allow for feedback. To solicit feedback, a link - CHNAFeedback@osfhealthcare.org – was provided on the hospital's website; however, no feedback was received.

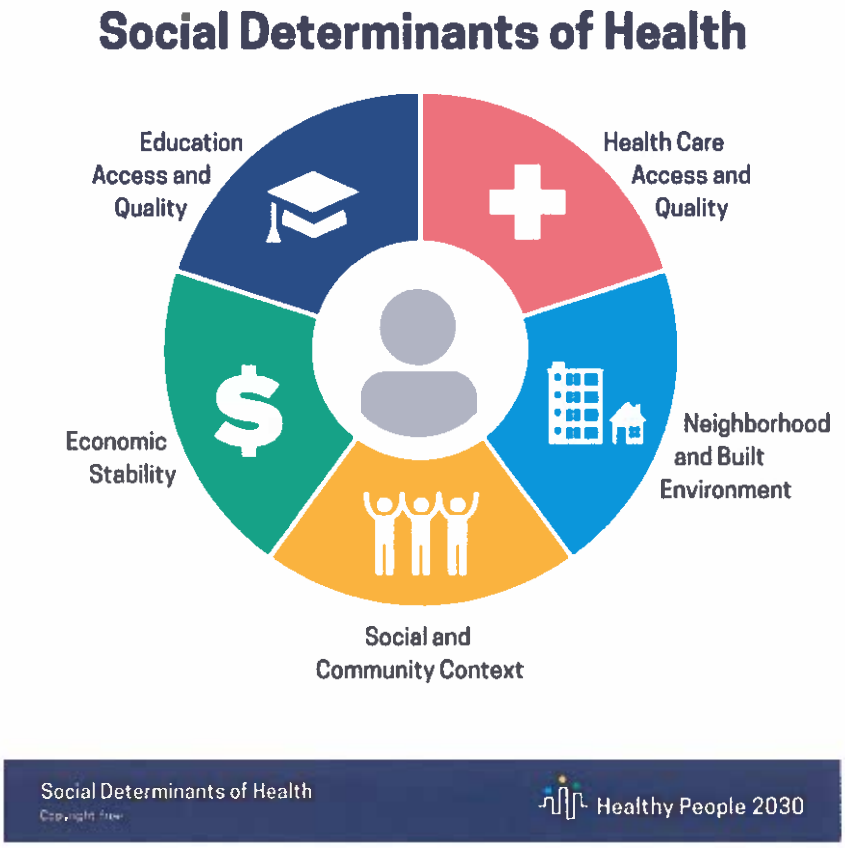
Although no written feedback was received by community members via the available mechanisms, verbal feedback from key stakeholders from community-service organizations was incorporated into the collaborative process.

Social Drivers of Health

This CHNA incorporates important factors associated with Social Drivers of Health (SDOH). SDOH are crucial environmental factors, such as where people are born, live, work and play, that affect people's well-being, physical and mental health, and quality of life. Research by the U.S. Department of Health and Human Services, as part of *Healthy People 2030*, identifies five SDOH to include when assessing community health (Figure 2). Note this CHNA refers to social "drivers" rather than "determinants."

According to the *Root Cause Coalition*, drivers are malleable, while determinants are not. However, the five factors included in Figure 2 remain the same, regardless of terminology used.

Figure 2



Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved November 1, 2024, from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

The CHNA includes an assessment of SDOH because these factors contribute to health inequities and disparities. Interventions without considering SDOH will have limited impact on improving community health for people living in underserved or at-risk areas.

II. METHODS

To complete the comprehensive community health needs assessment, multiple sources were examined. Secondary statistical data were used to assess the community profile, morbidity rates, and causes of mortality. Additionally, a study was conducted to examine perceptions of community health-related issues, healthy behaviors, behavioral health, food security, social drivers of health, and access to healthcare.

Secondary Data Collection

Existing secondary statistical data were first used to develop an overall assessment of health-related issues in the community. Each section of the report includes definitions, the importance of categories, data, and interpretations. At the end of each chapter, there is a section on key takeaways.

Based on several retreats, a separate OSF Collaborative Team used COMPdata Informatics (affiliated with Illinois Health and Hospital Association (IHA)) to identify six primary categories of diseases: age related, cardiovascular, respiratory, cancer, diabetes, and infections. To define each disease category, modified definitions developed by Sg2 were used. Sg2 specializes in consulting for healthcare organizations, and their team of experts includes MDs, PhDs, RNs and healthcare leaders with extensive strategic, operational, clinical, academic, technological, and financial experience.

Primary Data Collection

In addition to existing secondary data sources, primary survey data were also collected. This section describes the research methods used to collect, code, verify, and analyze primary survey data. Specifically, it covers the research design used for this study: survey design, data collection, and data integrity.

Survey Instrument Design

Initially, all publicly available health needs assessments in the U.S. were reviewed to identify common themes and approaches to collecting community health needs data. By leveraging best practices from these surveys, a new survey was designed in 2024 for use with both the general population and the at-risk community. To ensure all critical areas were addressed, the entire collaborative team was involved in survey design and approval through several fact-finding sessions. Additionally, several focus groups were used to collect the qualitative information necessary to design survey items. Specifically, for the community health needs assessment, eight specific sets of items were included:

- **Ratings of health issues in the community** – To assess the importance of various community health concerns. Survey items included assessments of topics such as cancer, diabetes, and obesity.
- **Ratings of unhealthy behaviors in the community** – To assess the importance of various unhealthy behaviors. Survey items included assessments of topics such as violence, drug use, and smoking.
- **Ratings of issues concerning well-being** – To assess the importance of various issues relating to well-being in the community. Survey items included assessments of topics such as access to healthcare, safer neighborhoods, and effective public transportation.
- **Accessibility to healthcare** – To assess the degree to which residents could access healthcare when needed. Survey items included assessments of topics such as access to medical, dental, and mental healthcare, as well as access to prescription medication.

- **Healthy behaviors** – To assess the degree to which residents exhibited healthy behaviors. The survey items included assessments of topics such as exercise, healthy eating habits, and cancer screenings.
- **Behavioral health** – To assess community issues related to areas such as anxiety and depression.
- **Food security** – To assess access to healthy food alternatives.
- **Social drivers of health** – To assess the impact that social drivers may have on the above-mentioned areas.

Finally, demographic information was collected to assess the background information necessary to segment markets in terms of the eight categories discussed above. A copy of the final survey is included in APPENDIX 2. SURVEY.

Sample Size

To identify the potential population, the percentage of the Lee County population living in poverty was first identified. Specifically, the county's population was multiplied by its respective poverty rate to determine the minimum sample size needed to study the at-risk population. The poverty rate for Lee County was 10.1%. With a population of 34,058, this yielded a total of 3,440 residents living in poverty in the Lee County area.

A normal approximation to the hypergeometric distribution was assumed, given the targeted sample size. The formula used was:

$n = (Nz2pq)/(E2 (N-1) + z2 pq)$

where:

n = the required sample size

N = the population size

z = the value that specified the confidence interval (use 95% CI)

pq = population proportions (set at .05)

E =desired accuracy of sample proportions (set at +/- .05)

For the total Lee County area, the minimum sample size for aggregated analyses (combining at-risk and general populations) was 382. The data collection effort for this CHNA yielded a total of 530 responses. After cleaning the data for "bot" survey respondents, the sample was reduced to 444 respondents. This met the threshold of the desired 95% confidence interval.

To provide a representative profile when assessing the aggregated population for the Lee County region, the general population was combined with a portion of the at-risk population. To represent the at-risk population as a percentage of the aggregate population, a random-number generator was used to select at-risk cases to include in the general sample. Additionally, efforts were made to ensure that the demography of the sample aligned with population demographics according to U.S. Census data. This

provided a total usable sample of 428 respondents for analyzing the aggregate population. Sample characteristics can be seen in APPENDIX 3. CHARACTERISTICS OF SURVEY RESPONDENTS.

Data Collection

Survey data were collected in the 1st quarter of 2025. To collect data in this study, two techniques were used. First, an online version of the survey was created. Second, a paper version of the survey was distributed. To be sensitive to the needs of respondents, surveys stressed assurance of complete anonymity. Both the online survey and paper survey were also translated into Spanish.

To specifically target the at-risk population, surveys were distributed at homeless shelters, food pantries, and soup kitchens. Since the at-risk population was specifically targeted as part of the data collection effort, this became a stratified sample, as other groups were not targeted based on their socio-economic status.

It is important to note that the use of electronic surveys to collect community-level data may create potential for bias from convenience sampling errors. To account for potential bias in the community sample, a second control sample of data is periodically collected. This control sample consists of random patients surveyed at the hospital, if patients receiving care represent an unbiased representation of the community. All questions on the patient version of the survey pertaining to access to healthcare are removed, as these questions are not relevant to current patients. Data from the community sample and the control sample are then compared using t-tests and tetrachoric correlations when appropriate. Results show that the community sample did not exhibit any significant patterns of bias. If specific relationships exhibited potential bias between the community sample and the control sample, they are identified in the social drivers sections of the analyses within each chapter.

Data Integrity

Comprehensive analyses were performed to verify the integrity of the data for this research. Without proper validation of the raw data, any interpretation of results could be inaccurate and misleading if used for decision-making. Therefore, several tests were performed to ensure the data were valid. These tests were performed before any analyses were undertaken. Data were checked for coding accuracy using descriptive frequency statistics to verify that all data items were correct. This was followed by analyses of means and standard deviations and comparisons of primary data statistics to existing secondary data.

Analytic Techniques

To ensure statistical validity, several different analytic techniques were used. Frequencies and descriptive statistics were employed to identify patterns in residents' ratings of various health concerns. Additionally, appropriate statistical techniques were used to identify existing relationships between perceptions, behaviors, and demographic data. Specifically, Pearson correlations, X^2 tests and tetrachoric correlations were utilized when appropriate, given the characteristics of the specific data being analyzed.

CHAPTER 1 OUTLINE

1.1 Population
1.2 Age, Gender and Race Distribution
1.3 Household/Family
1.4 Economic Information
1.5 Education
1.6 Internet Accessibility
1.7 Key Takeaways from Chapter 1

CHAPTER 1: DEMOGRAPHY AND SOCIAL DRIVERS

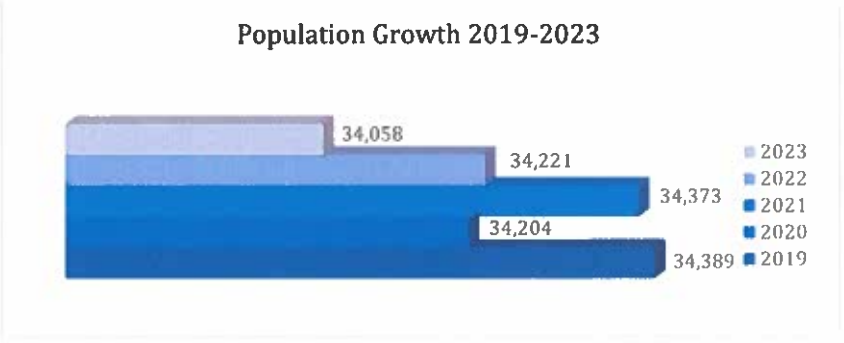
1.1 Population

Importance of the Measure: Population data characterize individuals residing in Lee County. This data provides an overview of population growth trends and builds a foundation for further analysis.

Population Growth

Data from the last census indicates that the population of Lee County slightly decreased (<1%) between 2019 and 2023 (Figure 3).

Figure 3



Source: United States Census Bureau

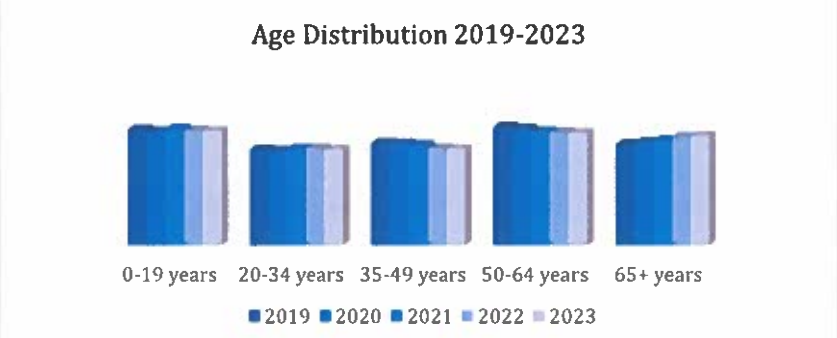
1.2 Age, Gender and Race Distribution

Importance of the Measure: Population data broken down by age, gender, and race groups provide a foundation to analyze the issues and trends impacting demographic factors, including economic growth and the distribution of healthcare services. Understanding the cultural diversity of communities is essential when considering healthcare infrastructure and service delivery systems.

Age

As illustrated in Figure 4, the percentage of individuals in Lee County in each age group, except for the 65+ age group, declined over the five-year period from 2019 to 2023. Most notably, those in the 35-49 and 50-64 age groups declined 5.7% and 5.20%, respectively. The 65+ age group increased by 8.32% over the same period.

Figure 4



Source: United States Census Bureau

Gender

The gender distribution of Lee County residents is relatively equal among males and females (Figure 5).

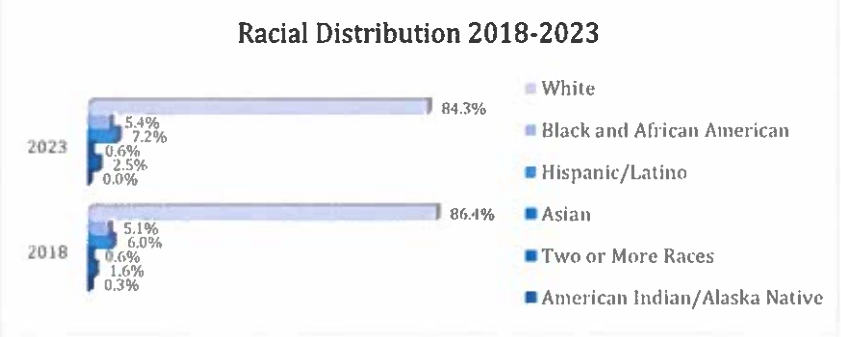
Figure 5

Source: United States Census Bureau

Race

With regard to race and ethnic background, Lee County is largely homogenous. However, in recent years, the county is becoming more diverse. Data from 2023 suggest that White ethnicity comprises 84.3% of the population in Lee County. The non-White population has been increasing, rising from 13.6% in 2018 to 15.7% in 2023. Within this, Hispanic/Latino ethnicity comprises 7.2% of the population and Black and African American ethnicity comprises 5.4% of the population (Figure 6).

Figure 6



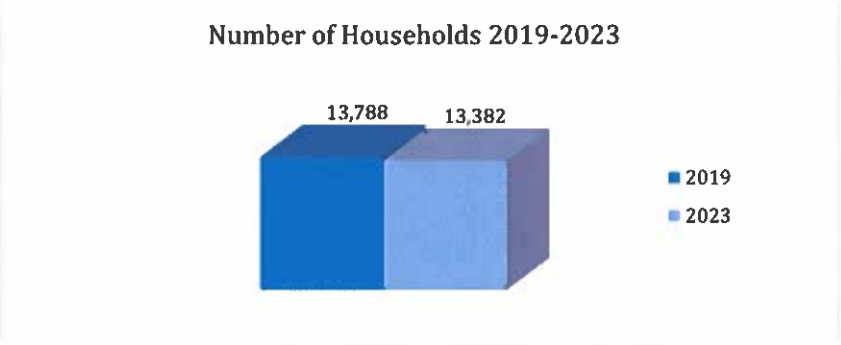
Source: United States Census Bureau

1.3 Household/Family

Importance of the Measure: Families are a vital component of a robust society in Lee County, as they significantly impact the health and development of children and provide support and well-being for older adults.

As indicated in the graph below, the number of family households in Lee County decreased from 13,788 in 2019 to 13,382 in 2023 (Figure 7).

Figure 7

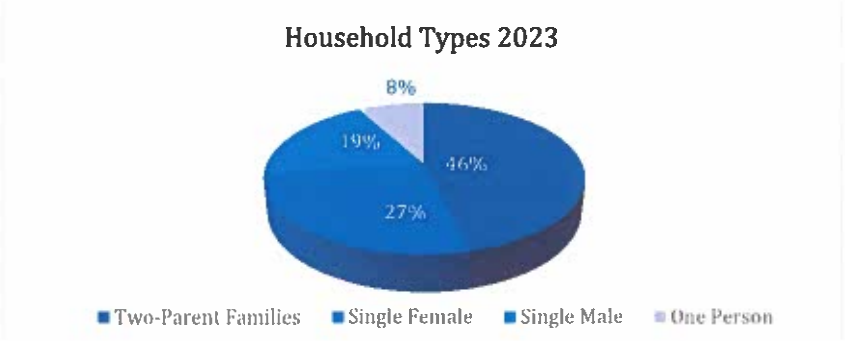


Source: United States Census Bureau

Family Composition

In Lee County, data from 2023 show that two-parent families make up 46% of households. One-person households represent 8% of the county population, single-female households represent 27%, and single-male households account for 19% (Figure 8).

Figure 8



Source: United States Census Bureau

Early Sexual Activity Leading to Births from Teenage Mothers

Lee County has experienced fluctuations in teenage birth count. The count steadily declined from 2018 to 2020, then increased in 2021 and 2022. Over the five-year period from 2018-2022, the overall trend in the teen births has been upward (Figure 9).

Figure 9

Source: Illinois Department of Public Health

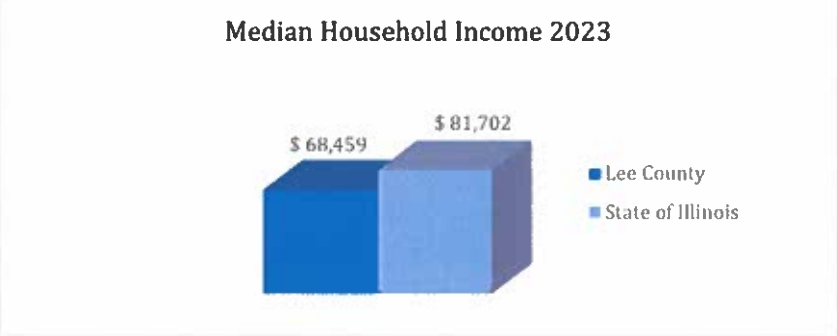
1.4 Economic Information

Importance of the Measure: Median income divides households into two segments, with one-half of households earning more than the median income and the other half earning less. Because median income is not significantly impacted by unusually high or low-income values, it is considered a more reliable indicator than average income. Living in poverty means lacking sufficient income to meet one's basic needs. Accordingly, poverty is associated with numerous chronic social, health, education, and employment conditions.

Median Income Level

For 2023, the median household income in Lee County ($68,459) was lower than that of the State of Illinois ($81,702) (Figure 10).

Figure 10

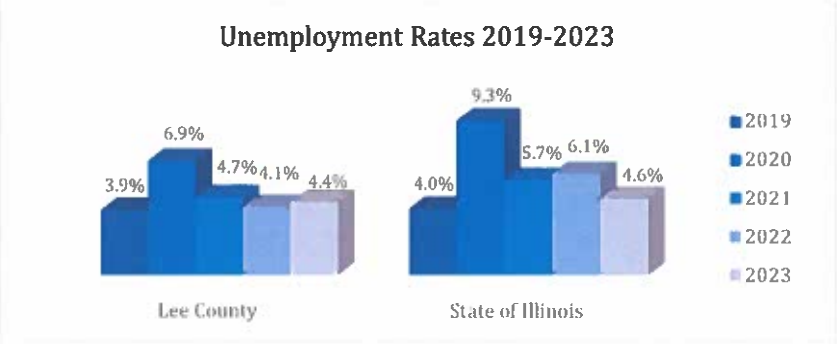


Source: United States Census Bureau

Unemployment

From 2019 through 2023, the Lee County unemployment rate remained lower than the State of Illinois' unemployment rate (Figure 11). Some of the increase in unemployment in 2020 may be attributed to the COVID-19 pandemic.

Figure 11

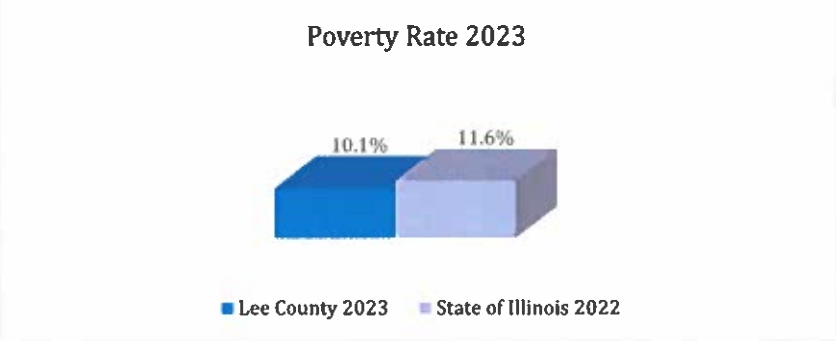


Source: Bureau of Labor Statistics

Individuals in Poverty

In Lee County, the percentage of individuals living in poverty was 10.1%, which is lower than the State of Illinois poverty rate (11.6%). Poverty significantly impacts the development of children and youth (Figure 12). The most recent available poverty rate data for the State of Illinois is from 2022.

Figure 12



Source: United States Census Bureau

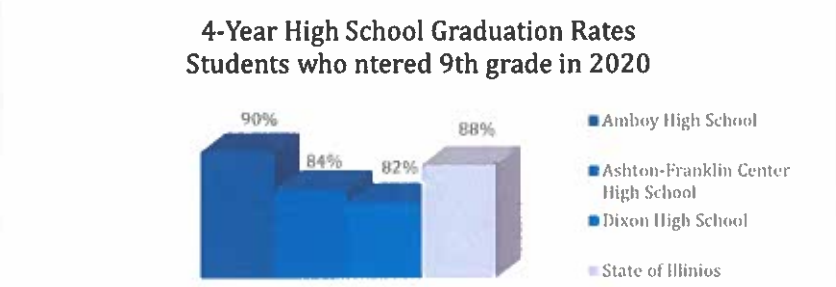
1.5 Education

Importance of the Measure: According to the National Center for Educational Statistics, "The better educated a person is, the more likely that person is to report being in 'excellent' or 'very good' health, regardless of income." Research suggests that higher educational attainment and greater school success lead to better health outcomes and a higher likelihood of making healthy lifestyle choices. Consequently, years of education are strongly related to an individual's propensity to earn a higher salary, secure better employment, and achieve multifaceted success in life.

High School Graduation Rates

In 2020, the Amboy High School (90%) district in Lee County reported high school graduation rates exceeding the State of Illinois average of 88%. Meanwhile, Ashton-Franklin Center High School (84%) and Dixon High School (82%) recorded lower graduation rates than the State of Illinois rate (Figure 13).

Figure 13

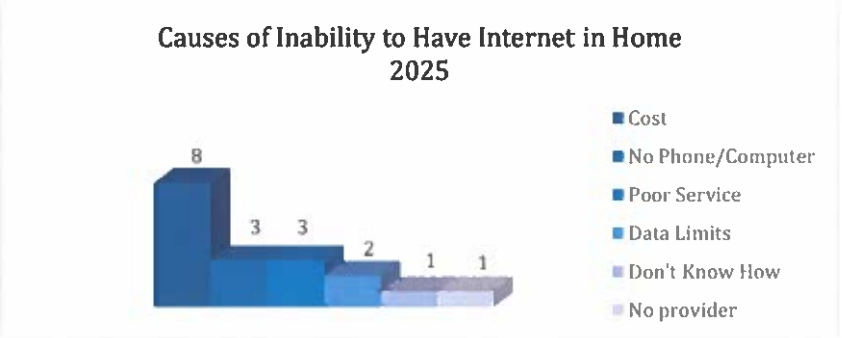


Source: Illinois Report Card

1.6 Internet Accessibility

Survey respondents were asked if they had Internet access. Of the respondents, 96% indicated they had Internet in their homes. For those who did not have Internet in their home, cost was the most frequently cited reason (Figure 14). Note that these data are displayed in frequencies rather than percentages due to the low number of responses.

Figure 14



Source: CHNA Survey

Social Drivers Related to Internet Access

Several factors show significant relationships with an individual's Internet access. The following relationships were found using correlational analyses:

- **Access to Internet** tends to be rated higher for younger people, those with higher education, and those with higher income.

1.7 Key Takeaways from Chapter 1

- ✓ POPULATION DECREASED OVER THE LAST 5 YEARS.
- ✓ POPULATION OVER AGE 65 IS INCREASING.
- ✓ SINGLE FEMALE HEAD-OF-HOUSEHOLD REPRESENTS 27% OF THE POPULATION. HISTORICALLY, THIS DEMOGRAPHIC INCREASES THE LIKELIHOOD OF FAMILIES LIVING IN POVERTY.

CHAPTER 2 OUTLINE

2.1 Accessibility
2.2 Wellness
2.3 Access to Information
2.4 Physical Environment
2.5 Health Status
2.6 Key Takeaways from Chapter 2

CHAPTER 2: PREVENTION BEHAVIORS

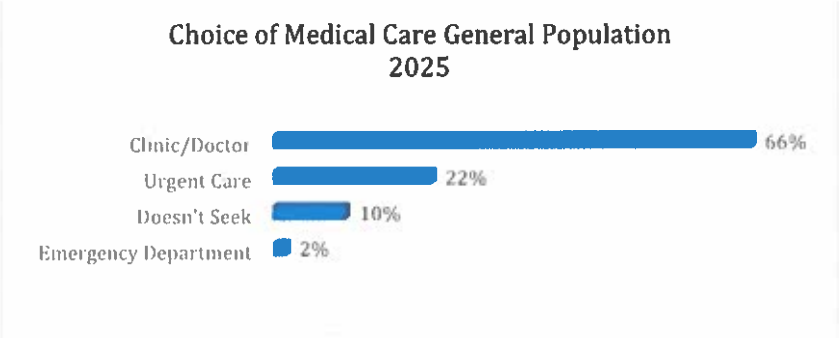
2.1 Accessibility

Importance of the Measure: It is critical for healthcare services to be accessible. Therefore, accessibility to healthcare must address both the associated financial costs and the supply and demand of medical services.

Choice of Medical Care

Survey respondents were asked to select the type of healthcare facility they used when sick. Four different options were presented: clinic or doctor's office, urgent-care facility, did not seek medical treatment, and emergency department. The most common response for source of medical care was clinic/doctor's office, chosen by 66% of survey respondents. This was followed by urgent care (22%), not seeking medical attention (10%), and the emergency department at a hospital (2%) (Figure 15).

Figure 15



Source: CHNA Survey

Social Drivers Related to Choice of Medical Care

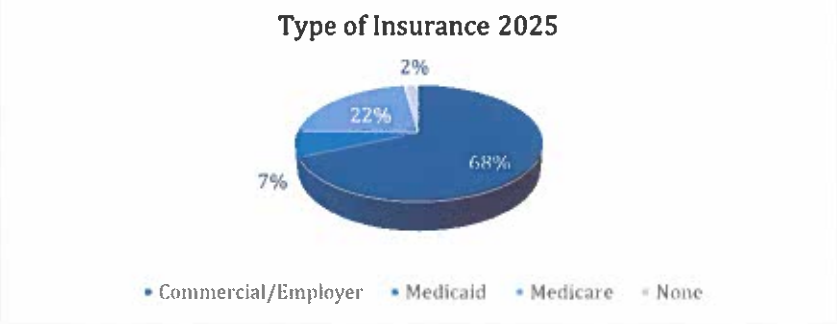
Several factors show significant relationships with an individual's choice of medical care. The following relationships were found using correlational analyses.

- **Clinic/Doctor's Office** tends to be used more often by older people.
- **Urgent Care** tends to be used more often by younger people.
- **Emergency Department** does not have any significant correlates.
- **Does Not Seek Medical Care** tends to be chosen more by men.

Insurance Coverage

According to survey data, 68% of the residents are covered by commercial/employer insurance, followed by Medicare (22%) and Medicaid (7%). Only 2% of respondents indicated they did not have any health insurance (Figure 16).

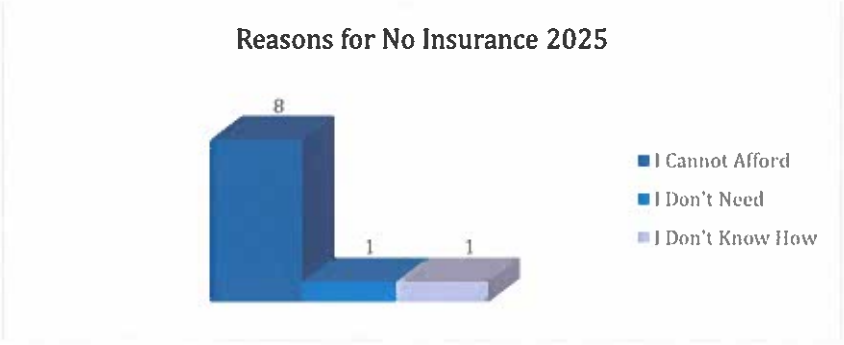
Figure 16



Source: CHNA Survey

Data from the survey show that for those individuals who do not have insurance, the most prevalent reason was cost (Figure 17). Note that these data are displayed in frequencies rather than percentages given the low number of responses.

Figure 17



Source: CHNA Survey

Social Drivers Related to Type of Insurance

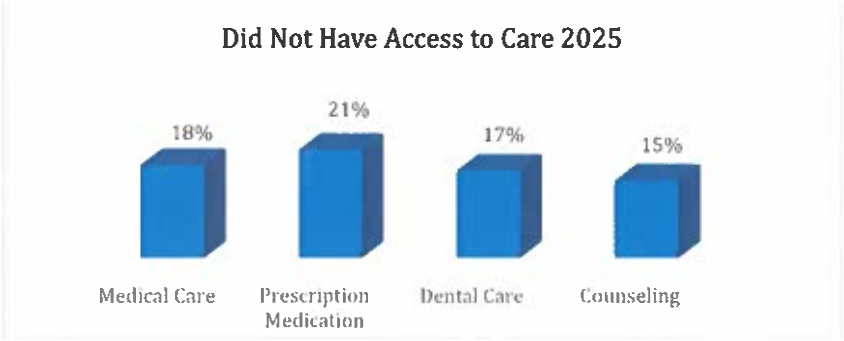
Several characteristics show significant relationships with an individual's type of insurance. The following relationships were found using correlational analyses.

- **Medicare** tends to be used more frequently by older people, those with lower education, those with lower income, and those in an unstable housing environment.
- **Medicaid** tends to be used more frequently by those with lower education and those with lower income.
- **Private Insurance** is used more often White people, those with higher education, and those with higher income. Private insurance is less often used by younger people and those in an unstable housing environment.
- **No Insurance** did not have any significant correlates.

Access to Care

In the CHNA survey, respondents were asked, "Was there a time when you needed care but were not able to get it?" Access to four types of care were assessed: medical care, prescription medication, dental care, and counseling. Survey results show that 18% of the population did not have access to medical care when needed; 21% did not have access to prescription medication when needed; 17% did not have access to dental care when needed; and 15% did not have access to counseling when needed (Figure 18).

Figure 18



Source: CHNA Survey

Social Drivers Related to Access to Care

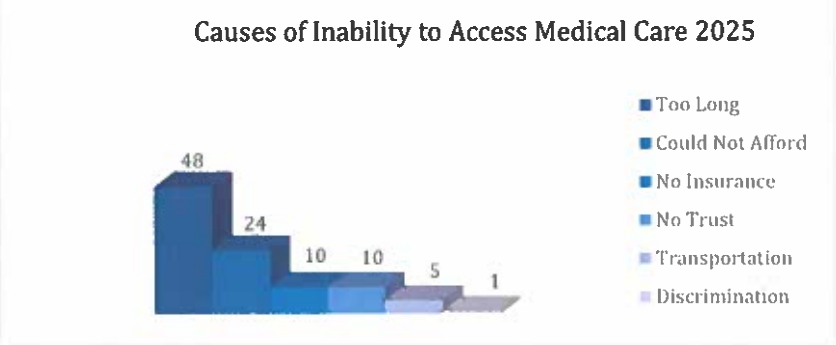
Several characteristics show a significant relationship with an individual's ability to access care when needed. The following relationships were found using correlational analyses.

- **Access to medical care** tends to be rated higher for those with higher income. Access to medical care tends to be rated lower for those with an unstable housing environment.
- **Access to prescription medication** tends to be rated higher for those with higher income. Access to prescription medication tends to be rated lower for those with an unstable housing environment.
- **Access to dental care** tends to be rated higher those with higher education and those with higher income. Access to dental care tends to be rated lower by those with an unstable housing environment.
- **Access to counseling** did not have any signification correlates.

Reasons for No Access – Medical Care

Survey respondents who reported they were not able to get medical care when needed were asked a follow-up question. Based on frequencies, the leading causes of the inability to gain access to medical care were too long to wait for an appointment (48) and inability to afford the copay (24) (Figure 19).

Figure 19

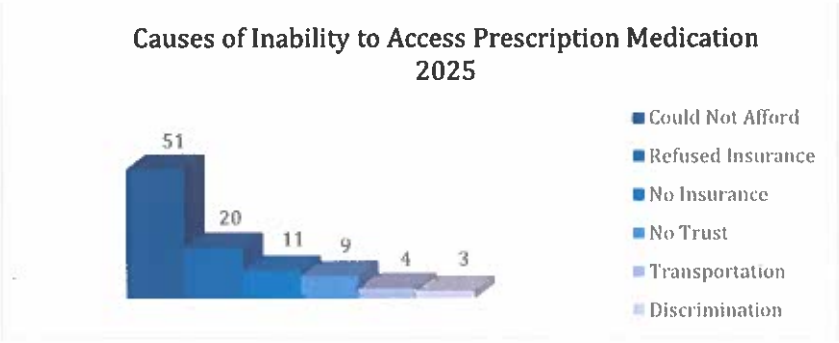


Source: CHNA Survey

Reasons for No Access – Prescription Medication

Survey respondents who reported they were not able to get prescription medication when needed were asked a follow-up question. Based on frequencies, the leading cause of the inability to gain access to prescription medicine was the inability to afford copayments or deductibles (51) (Figure 20).

Figure 20

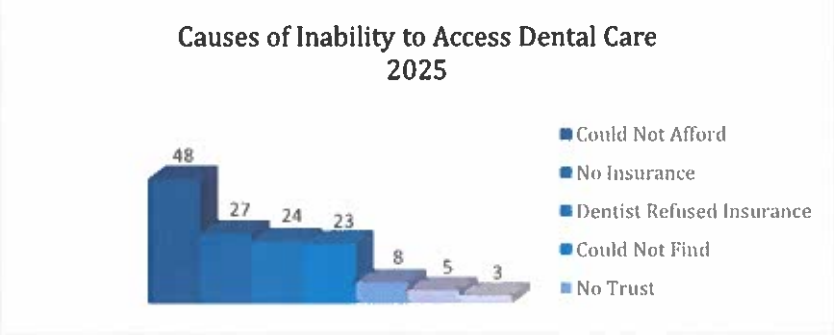


Source: CHNA Survey

Reasons for No Access – Dental Care

Survey respondents who reported they were not able to get dental care when needed were asked a follow-up question. Based on frequencies, the leading cause of the inability to gain access to dental care was the inability to afford copayments or deductibles (48) (Figure 21).

Figure 21

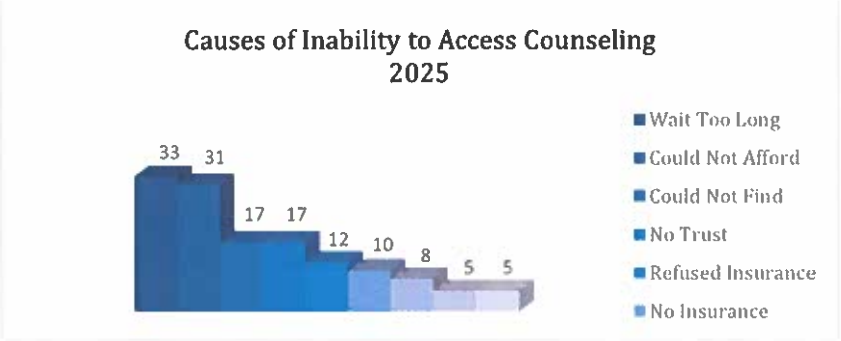


Source: CHNA Survey

Reasons for No Access – Counseling

Survey respondents who reported they were not able to get counseling when needed were asked a follow-up question. Based on frequencies, the leading causes of the inability to gain access to counseling were long waiting times (33) and the inability to afford copay or deductible (31) (Figure 22).

Figure 22



Source: CHNA Survey

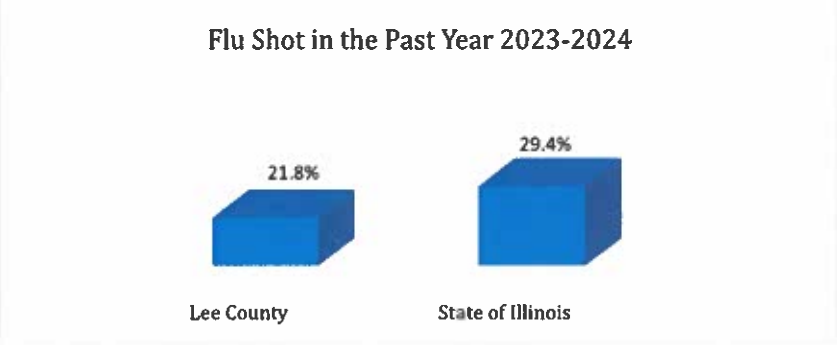
2.2 Wellness

Importance of the Measure: The overall health of a community is impacted by preventative measures, including immunizations and vaccinations. Preventative healthcare measures, such as getting a flu shot, engaging in a healthy lifestyle, and undertaking screenings for diseases, are essential to combating morbidity and mortality while reducing healthcare costs.

Frequency of Flu Shots

Figure 23 shows that, from the period 2023 to 2024, 21.8% of people in Lee County received a flu shot. This vaccination percentage was lower than the State of Illinois average, standing at 29.4% (Figure 23).

Figure 23

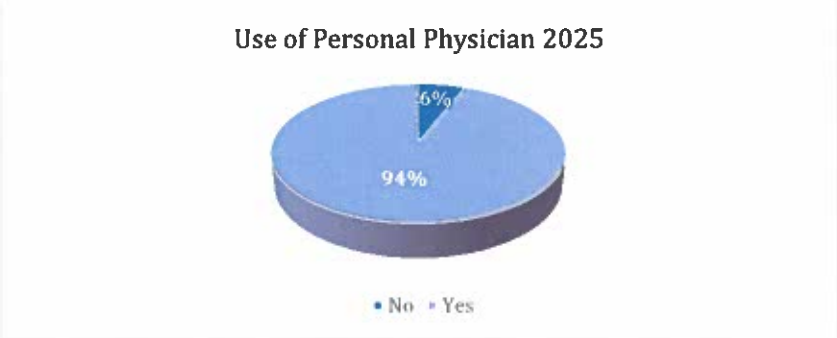


Source: Illinois Department of Public Health (IDPH)

Personal Physician

The CHNA survey asked respondents if they had a personal physician. Having a personal physician suggests that individuals are more likely to get wellness check-ups and less likely to use an emergency department as a primary healthcare service. According to survey data, 94% of residents have a personal physician (Figure 24).

Figure 24



Source: CHNA Survey

Social Drivers Related to Having a Personal Physician

One characteristic shows a significant relationship with having a personal physician. The following relationship was found using correlational analyses.

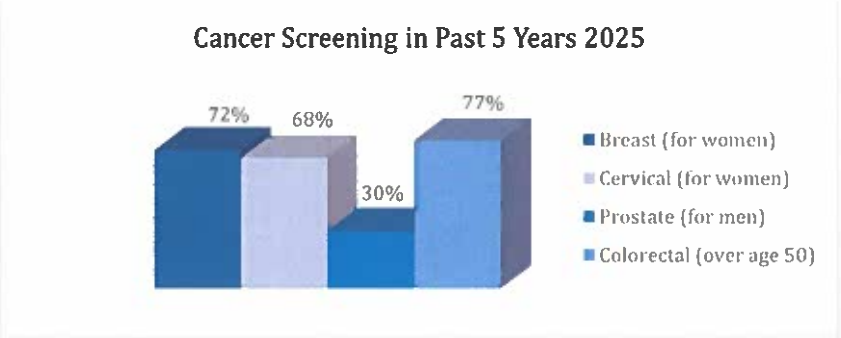
- **Having a personal physician** tends to be more likely for those with higher education.

Cancer Screening

Early detection of cancer can greatly improve the probability of successful treatment. In the case of colorectal cancer, early detection of precancerous polyps can prevent cancer. Specifically, four types of cancer screening were measured: breast, cervical, prostate, and colorectal.

Results from the CHNA survey show that 72% of women had a breast screening and 68% had a cervical screening in the past five years. For men, 30% had a prostate screening in the past five years. For women and men over the age of 50, 77% had a colorectal screening in the last five years (Figure 25).

Figure 25



Source: CHNA Survey

Social Drivers Related to Cancer Screenings

Multiple characteristics show significant relationships with cancer screening. The following relationships were found using correlational analyses.

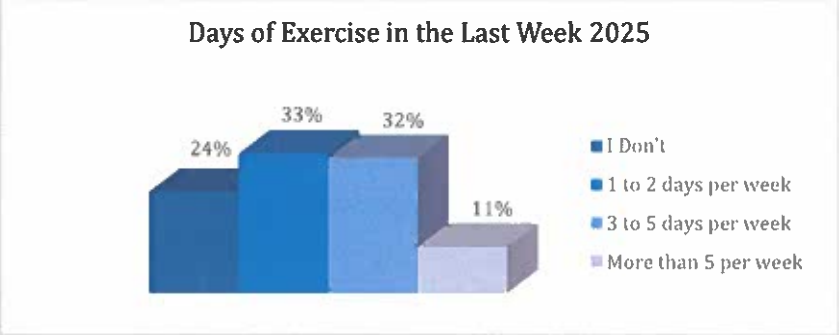
- **Breast screening** tends to be more likely for older women. Those women who are not White and women in an unstable housing environment are less likely to have a breast screening.
- **Cervical screening** tends to be less likely for older women.
- **Prostate screening** tends to be more likely for older men and White men.
- **Colorectal screening** tends to be more likely for older people. Those in an unstable housing environment are less likely to have a colorectal screening.

Physical Exercise

A healthy lifestyle, comprised of regular physical activity, has been shown to increase physical, mental, and emotional well-being.

Specifically, 24% of respondents indicated that they do not exercise at all, while the majority (65%) of residents exercise 1-5 times per week (Figure 26).

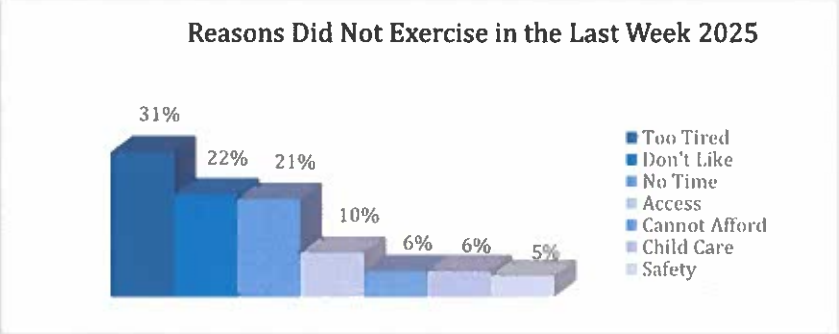
Figure 26



Source: CHNA Survey

To find out why some residents do not exercise at all, a follow up question was asked. The most common reasons for not exercising are not having enough energy (31%), a dislike of exercise (22%), and not having enough time (21%) (Figure 27).

Figure 27



Source: CHNA Survey

Social Drivers Related to Exercise

There were not any characteristics that show significant relationships with the frequency of exercise.

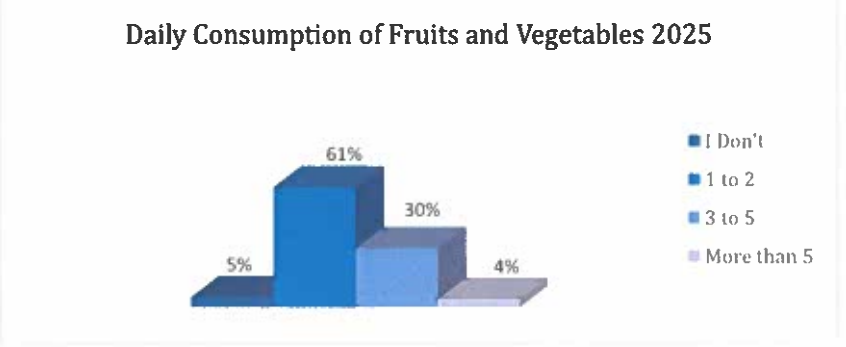
- **Frequency of exercise** did not have any significant correlates.

Healthy Eating

A healthy lifestyle, comprising a proper diet, has been shown to increase physical, mental, and emotional well-being. Consequently, nutrition and diet are critical to preventative care.

Almost two-thirds (66%) of residents report no consumption or low consumption (1-2 servings per day) of fruits and vegetables. Notably, only 4% of residents consume five or more servings per day (Figure 28).

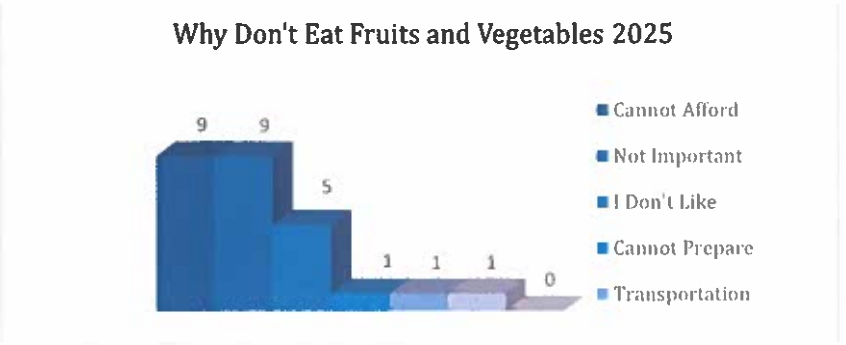
Figure 28



Source: CHNA Survey

Those individuals who indicated they do not eat any fruits or vegetables were asked a follow up question. The most frequently given reasons for failing to eat more fruits and vegetables were cannot afford (9), a lack of perceived importance (9), and dislike of fruits and vegetables (5) (Figure 29). Note that these data are displayed in frequencies rather than percentages due to the low number of responses.

Figure 29



Source: CHNA Survey

Social Drivers Related to Healthy Eating

Multiple characteristics show significant relationships with frequency of exercise. The following relationships were found using correlational analyses.

- **Consumption of fruits and vegetables** tends to be more likely for women and older people.

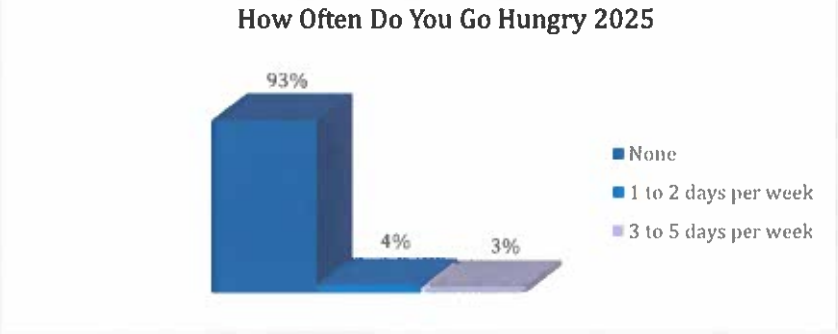
2.3 Understanding Food Insecurity

Importance of the Measure: It is essential that everyone has access to food and drink necessary for living healthy lives. Food insecurity exists when people don't have physical and economic access to sufficient, safe, and nutritious food that meets their dietary needs for a healthy life.

Prevalence of Hunger

Respondents were asked, "How many days a week do you or your family members go hungry?" The vast majority of respondents indicated they do not go hungry, however, 4% indicated they go hungry 1-2 days per week and 3% indicated they go hungry 3 to 5 days per week (Figure 30).

Figure 30



Source: CHNA Survey

Social Drivers Related to Prevalence of Hunger

Multiple characteristics show significant relationships with hunger. The following relationships were found using correlational analyses.

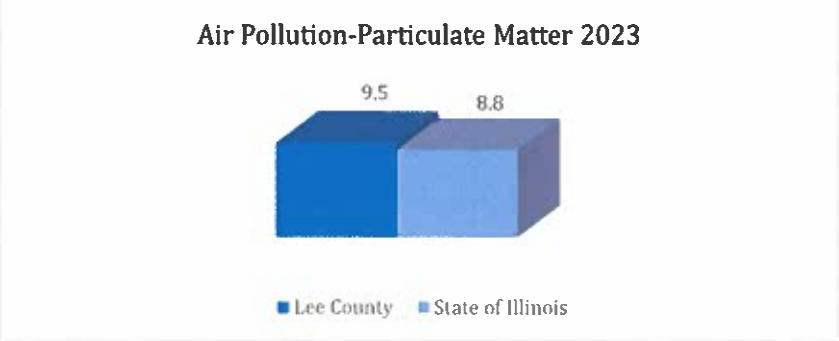
- **Prevalence of hunger** tends to be more likely for those in an unstable housing environment. It is less likely for women, White people, those with higher education, and those with higher income.

2.4 Physical Environment

Importance of the Measure: According to the County Health Rankings & Roadmaps, Air Pollution - Particulate Matter (APPM) is the average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers. These particles can be directly emitted from sources such as forest fires, or they can form when gases are emitted from power plants, manufacturing facilities and automobiles.

The relationship between elevated air pollution, particularly fine particulate matter and ozone, and compromised health has been well documented. Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects. The APPM for Lee County (9.5) is slightly higher than the State of Illinois average of 8.8 (Figure 31).

Figure 31



Source: County Health Rankings & Roadmaps

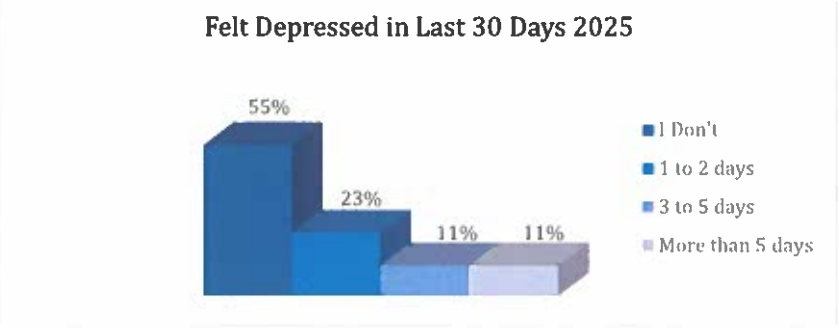
2.5 Health Status

Importance of the Measure: Self-perceptions of health can provide important insights to help manage population health. These perceptions not only provide benchmarks regarding health status but also offer insights into how accurately people perceive their own health.

Mental Health

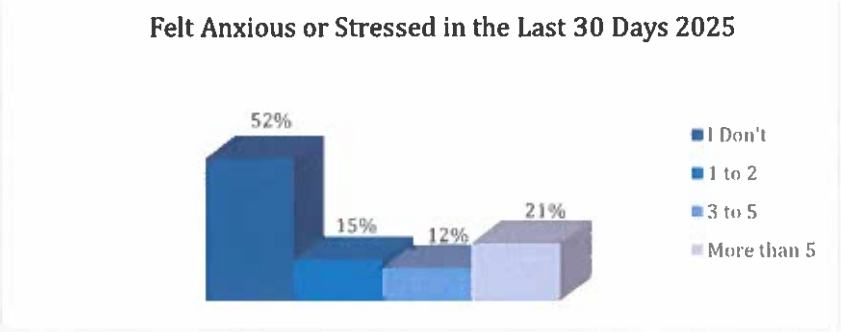
The survey asked respondents to indicate specific issues, such as depression and stress/anxiety. Of the respondents, 55% indicated they did not feel depressed in the last 30 days (Figure 32) and 52% indicated they did not feel anxious or stressed (Figure 33).

Figure 32



Source: CHNA Survey

Figure 33



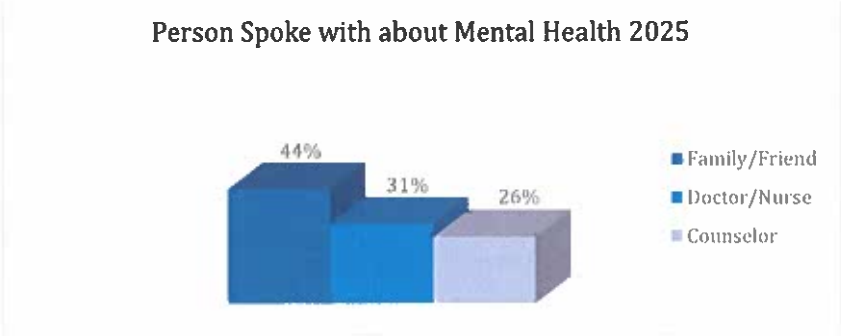
Source: CHNA Survey

Respondents were also asked if they spoke with anyone about their mental health in the past year. Of the respondents, 49% indicated that they spoke to someone (Figure 34), with the most common response was a family member or friend (44%) (Figure 35).

Figure 34

Source: CHNA Survey

Figure 35



Source: CHNA Survey

Social Drivers Related to Behavioral Health

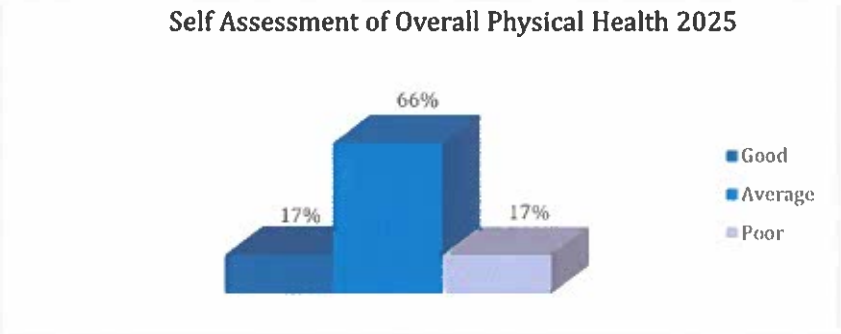
Multiple characteristics show significant relationships with behavioral health. The following relationships were found using correlational analyses.

- **Depression** tends to be rated higher for those in an unstable housing environment. Depression tends to be rated lower for those with higher income.
- **Stress and anxiety** tend to be rated higher for women and those in an unstable housing environment. Stress and anxiety tend to be rated lower by those who are older.

Self-Perceptions of Overall Health

In regard to self-assessment of overall physical health, 17% of respondents reported having poor overall physical health (Figure 36).

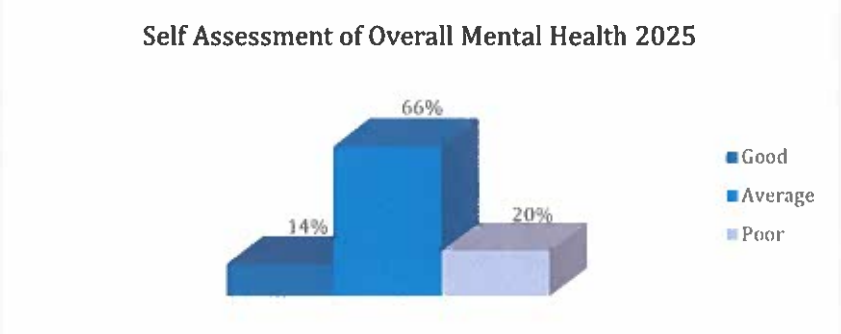
Figure 36



Source: CHNA Survey

In regard to self-assessment of overall mental health, 20% of respondents stated they have poor overall mental health (Figure 37).

Figure 37



Source: CHNA Survey

Social Drivers Related to Self-Perceptions of Health

Multiple characteristics show significant relationships with self-perceptions of health. The following relationships were found using correlational analyses.

- **Perceptions of physical health** tend to be lower for those with an unstable housing environment.
- **Perceptions of mental health** tend to be higher for those who are older. Perceptions of mental health tend to be lower for those with an unstable housing environment.

2.6 Key Takeaways from Chapter 2

- ✓ LACK OF ACCESS TO MEDICAL CARE (18%), PRESCRIPTION MEDICATION (21%), DENTAL CARE (17%) AND COUNSELING (15%) WHEN NEEDED IS RELATIVELY HIGH.
- ✓ UTILIZATION OF URGENT CARE (22%) AND PEOPLE NOT SEEKING MEDICAL CARE (10%) IS COMPARATIVELY HIGH.
- ✓ PROSTATE SCREENING IS RELATIVELY LOW COMPARED TO BREAST, CERVICAL, AND COLORECTAL SCREENING.
- ✓ EXERCISE AND HEALTHY EATING RATES IN THE PAST THREE YEARS HAVE BEEN LOW.
- ✓ 7% OF RESPONDENTS HAVE GONE HUNGRY AT LEAST ONE DAY A WEEK.
- ✓ ALMOST HALF OF THE POPULATION FELT DEPRESSED IN THE PAST 30 DAYS.
- ✓ 20% OF RESONDENTS INDICATE THEY HAVE POOR OVERALL MENTAL HEALTH.

CHAPTER 3 OUTLINE

3.1 Tobacco Use
3.2 Drug and Alcohol Use
3.3 Obesity
3.4 Predictors of Heart Disease
3.5 Key Takeaways from Chapter 3

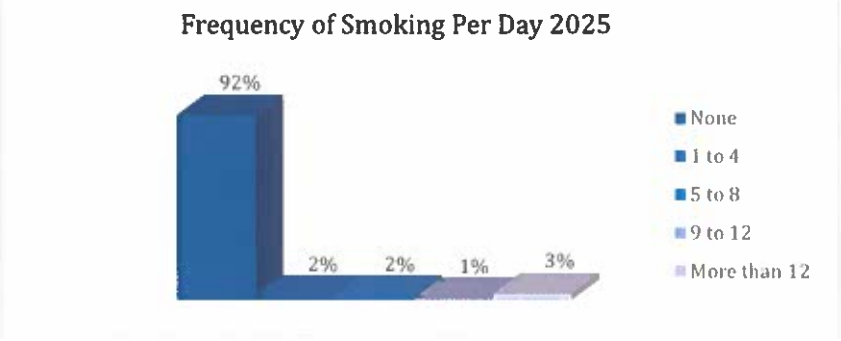
CHAPTER 3: SYMPTOMS AND PREDICTORS

3.1 Tobacco Use

Importance of the Measure: To appropriately allocate healthcare resources, a thorough analysis of the leading indicators regarding morbidity and disease must be conducted. In this way, healthcare organizations can target affected populations more effectively. Research suggests that tobacco use facilitates a wide variety of adverse medical conditions.

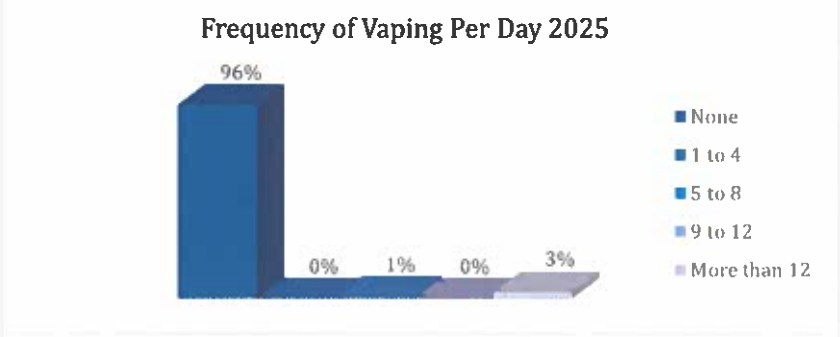
CHNA survey data show 92% of respondents do not smoke, and only 3% state they smoke more than 12 times per day (Figure 38). The percentage of those who state they vape on a daily basis is 4% and 3% vape more than 12 times per day (Figure 39).

Figure 38



Source: CHNA Survey

Figure 39



Source: CHNA Survey

Social Drivers Related to Smoking or Vaping

Multiple characteristics show significant relationships with smoking or vaping. The following relationships were found using correlational analyses.

- **Smoking** tends to be rated higher by those in an unstable housing environment. Smoking is rated lower by those with higher education.
- **Vaping** tends to be rated higher by those in an unstable housing environment. Vaping tends to be rated lower by those who are older.

3.2 Drug and Alcohol Use

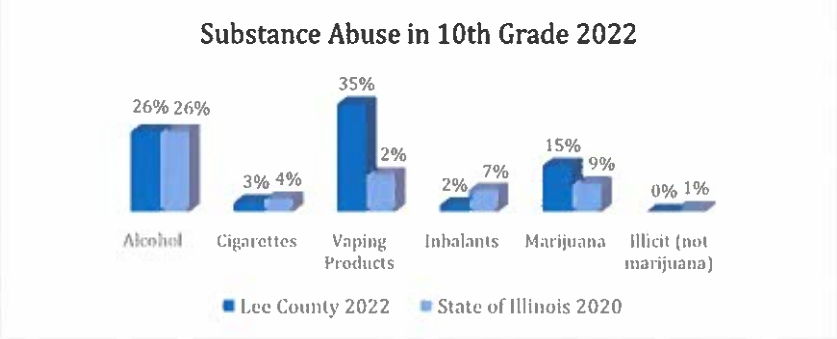
Importance of the Measure: Alcohol and drugs impair decision-making, often leading to adverse consequences and outcomes. Research suggests that alcohol is a gateway drug for youth, leading to increased usage of controlled substances in adulthood. Accordingly, the substance use values and behaviors of high school students are a leading indicator of adult substance use in later years.

Youth Substance Use

Data from the Illinois Youth Survey measures illegal substance use (alcohol, tobacco, and other drugs – including inhalants) among adolescents. Lee County data is reported for 2022, while State of Illinois data is reported for 2020. From the chart below, Lee County falls below or at the State of Illinois averages for alcohol, cigarettes, inhalants, and illicit drugs. However, Lee County reported significantly higher than State of Illinois averages for vaping products and marijuana among 10th graders (Figure 40).

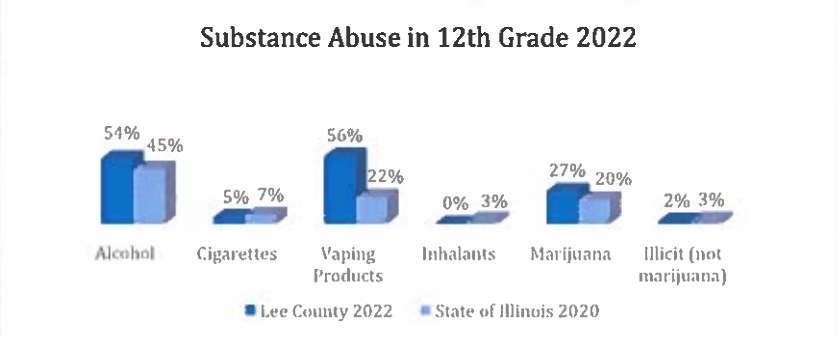
Among 12th graders, the most recent data available for Lee County is 2022 and the State of Illinois data is from 2020. These data show Lee County levels are significantly higher than State of Illinois averages in alcohol, vaping products, and marijuana. Lee County levels are lower for cigarettes, inhalants, and illicit drugs (Figure 41).

Figure 40



Source: University of Illinois Center for Prevention Research and Development

Figure 41

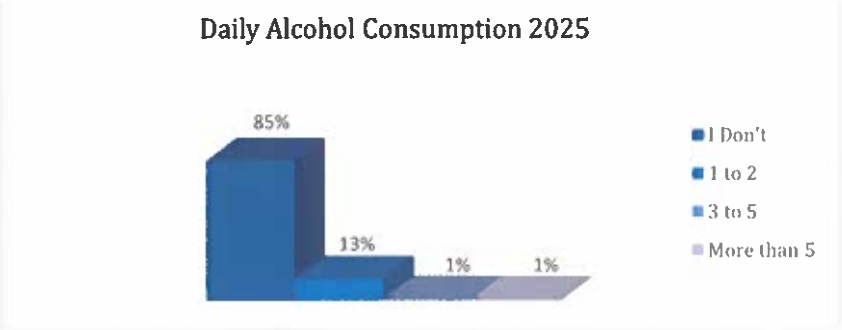


Source: University of Illinois Center for Prevention Research and Development

Adult Substance Use

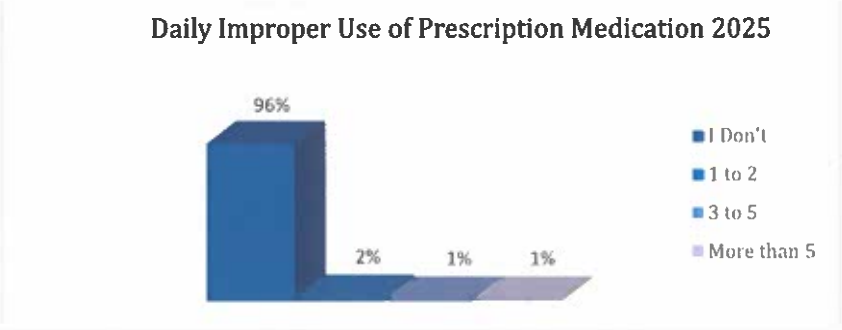
The CHNA survey asked respondents to indicate their usage of several substances. Of respondents, 85% indicated they did not consume alcohol on a typical day (Figure 42). Additionally, 96% indicated they do not take prescription medication improperly, including opioids, on a typical day (Figure 43). Furthermore 94% indicated they do not use marijuana on a typical day (Figure 44), and 99% indicated they do not use illegal substances on a typical day (Figure 45).

Figure 42



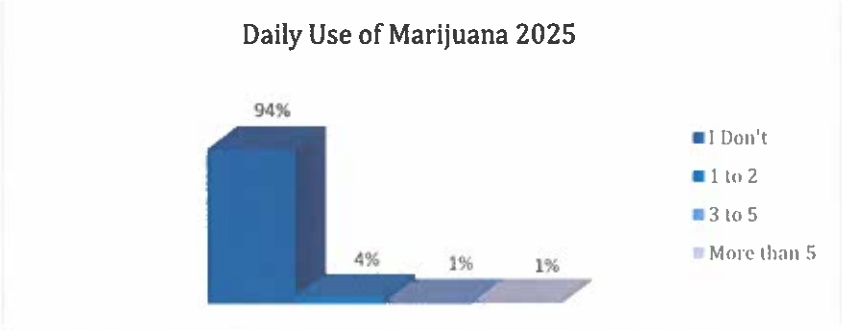
Source: CHNA Survey

Figure 43



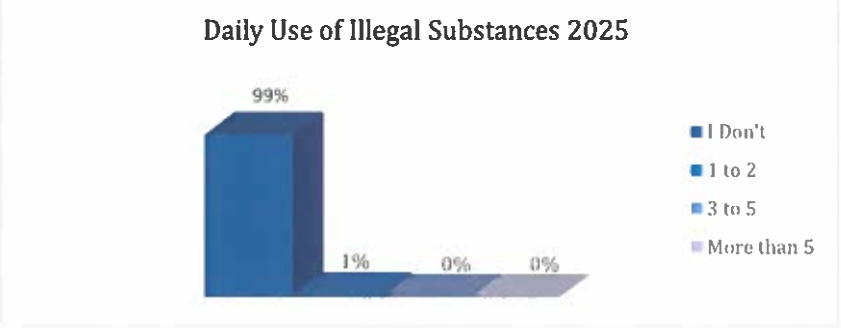
Source: CHNA Survey

Figure 44



Source: CHNA Survey

Figure 45



Source: CHNA Survey

Social Drivers Related to Substance Use

Multiple characteristics show significant relationships with substance use. The following relationships were found using correlational analyses.

- **Alcohol consumption** tends to be rated lower by women.
- **Misuse of prescription medication including opioids** tends to be rated higher by those with an unstable housing environment. Misuse of prescription medication tends to be rated lower by White people.
- **Marijuana use** tends to be rated higher by those with an unstable housing environment. Marijuana use tends to be rated lower by White people.
- **Illegal substance use** tends to be rated higher by those in an unstable housing environment. Illegal substance use tends to be rated lower by women and White people.

3.3 Obesity

Importance of the Measure: Individuals who are obese place greater stress on their internal organs, thus increasing their propensity to utilize health services. Research strongly suggests that obesity is a significant problem facing youth and adults nationally, in Illinois, and within Lee County. The US Surgeon General has characterized obesity as "the fastest-growing, most threatening disease in America today." According to the Obesity Prevention Initiative from the Illinois General Assembly, 20% of Illinois children are obese.

With children, research has linked obesity to numerous chronic diseases, including Type II diabetes, hypertension, high blood pressure, and asthma. Adverse physical health side effects of obesity include orthopedic problems due to weakened joints and lower bone density. Detrimental mental health side effects include low self-esteem, poor body image, symptoms of depression and suicide ideation. Obesity also impacts educational performance; studies suggest school absenteeism of obese children is six times higher than that of non-obese children.

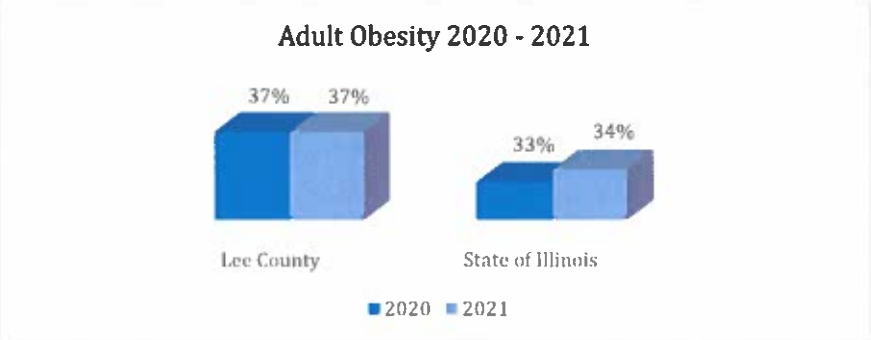
With adults, obesity has far-reaching consequences. Testimony to the Illinois General Assembly indicated that obesity-related illnesses contribute to worker absenteeism, slow workflow, and high worker compensation rates. A Duke University study on the effects of obesity in the workforce noted 13 times more missed workdays by obese employees than non-obese employees. Nationwide, lack of physical activity and poor nutrition contribute to an estimated 300,000 preventable deaths per year.

In Lee County, the number of people diagnosed with obesity has remained steady from 2020 to 2021. Note specifically that the percentage of obese people is 37%.

Obesity rates in Illinois slightly increased over the years from 2020 to 2021. Note specifically that the percentage of obese people has increased from 33% to 34% (Figure 46). Obesity is defined as body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).

Additionally, 2025 CHNA survey respondents indicated that being overweight was their most prevalent diagnosed health issue.

Figure 46

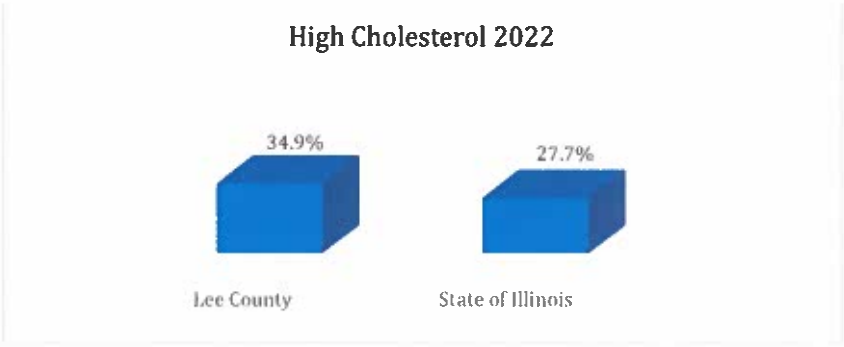


Source: County Health Rankings & Roadmaps

3.4 Predictors of Heart Disease

Residents in Lee County report a higher prevalence of high cholesterol compared to the State of Illinois average. The percentage of residents who report they have high cholesterol in Lee County (34.9%) compared to the State of Illinois average of 27.7% (Figure 47).

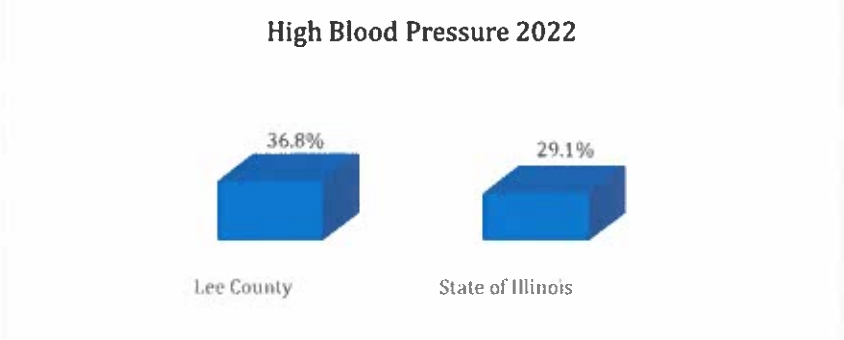
Figure 47



Source: Stanford Data Commons

With regard to high blood pressure, Lee County has a higher percentage of residents with high blood pressure (36.8%) compared to the State of Illinois average (29.1%) (Figure 48).

Figure 48



Source: Stanford Data Commons

3.5 Key Takeaways from Chapter 3

- ✓ VAPING PRODUCTS AND MARIJUANA USE AMONG 10TH GRADERS IS SIGNIFICANTLY HIGHER THAN STATE OF ILLINOIS AVERAGES.
- ✓ ALCOHOL, VAPING PRODUCTS, AND MARIJUANA USE AMONG 12TH GRADERS IS SIGNIFICANTLY HIGHER THAN STATE OF ILLINOIS AVERAGES.
- ✓ THE PERCENTAGE OF PEOPLE WHO ARE OBESE IS HIGHER THAN THE STATE OF ILLINOIS AVERAGES.
- ✓ RISK FACTORS FOR HEART DISEASE ARE HIGHER THAN STATE OF ILLINOIS AVERAGES.
- ✓ 4% OF SURVEY RESPONDENTS INDICATED THEY MISUSE PRESCRIPTION MEDICATION, INCLUDING OPIOIDS, ON A DAILY BASIS.

CHAPTER 4 OUTLINE

4.1 Self-Identified Health Conditions
4.2 Healthy Babies
4.3 Cardiovascular Disease
4.4 Respiratory
4.5 Cancer
4.6 Diabetes
4.7 Injuries
4.8 Mortality
4.9 Key Takeaways from Chapter 4

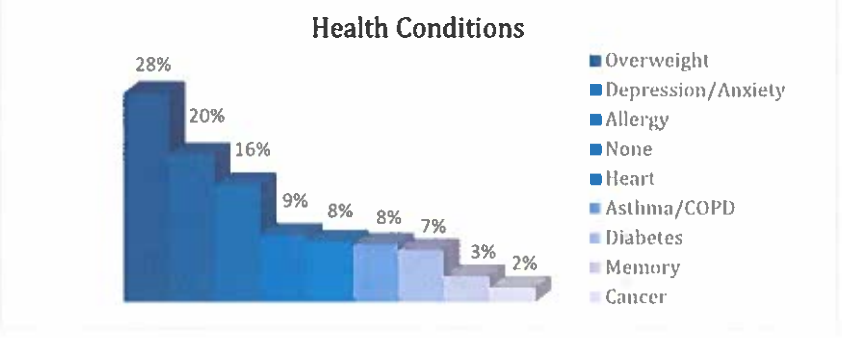
CHAPTER 4: MORBIDITY AND MORTALITY

Given the lack of recent disease/morbidity data from existing secondary data sources, much of the data used in this chapter was manually gathered from Lee County hospital-level data using COMPdata Informatics. Note that hospital-level data only show hospital admissions and do not reflect outpatient treatments and procedures.

4.1 Self-Identified Health Conditions

Survey respondents were asked to self-identify any health conditions. Notably, being overweight (28%) was significantly higher than any other reported health condition, followed by depression/anxiety (20%). Often percentages for self-identified data are lower than secondary data sources (Figure 49).

Figure 49



Source: CHNA Survey

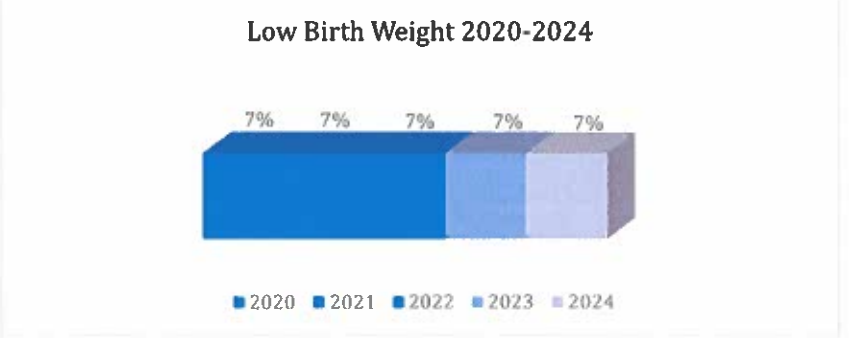
4.2 Healthy Babies

Importance of the Measure: Regular prenatal care is vital for producing healthy babies and children. Screening and treatment for medical conditions, as well as identifying and intervening in behavioral risk factors associated with poor birth outcomes, are crucial. Research suggests that women who receive adequate prenatal care are more likely to have better birth outcomes, such as full-term and normal-weight babies.

Low Birth Weight Rates

Low birth weight rate is defined as the percentage of infants born below 2,500 grams (5.5 pounds). Very low birth weight rate is defined as the percentage of infants born below 1,500 grams (3.3 pounds). In contrast, the average newborn weighs about 7 pounds. The percentage of babies born with low birth weight in Lee County has remained relatively constant at 7% over the period from 2020 to 2024 (Figure 50).

Figure 50



Source: County Health Rankings & Roadmaps

4.3 Cardiovascular Disease

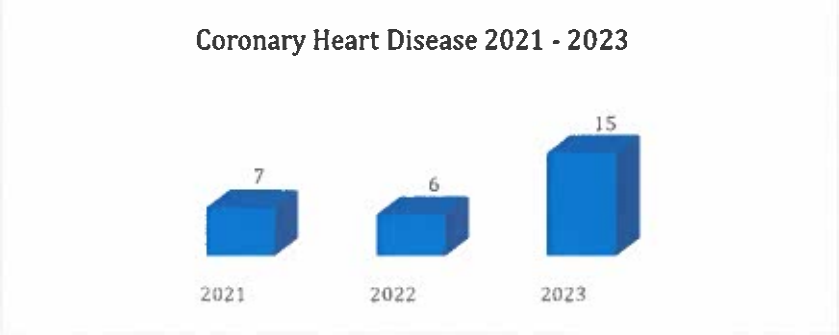
Importance of the Measure: Cardiovascular disease encompasses all diseases of the heart and blood vessels, including ischemic (also known as coronary) heart disease, cerebrovascular disease, congestive heart failure, hypertensive disease, and atherosclerosis.

Coronary Heart Disease

Coronary Heart Disease, sometimes-called atherosclerosis, can slowly narrow and/or harden the arteries throughout the body. Coronary artery disease is a leading cause of death for Americans. Most of these deaths resulting from heart attacks caused by sudden blood clots in the heart's arteries.

The number of cases of coronary atherosclerosis complications at Lee County area hospitals have had an overall increase from 7 in 2021 to 15 in 2023 (Figure 51).

Figure 51

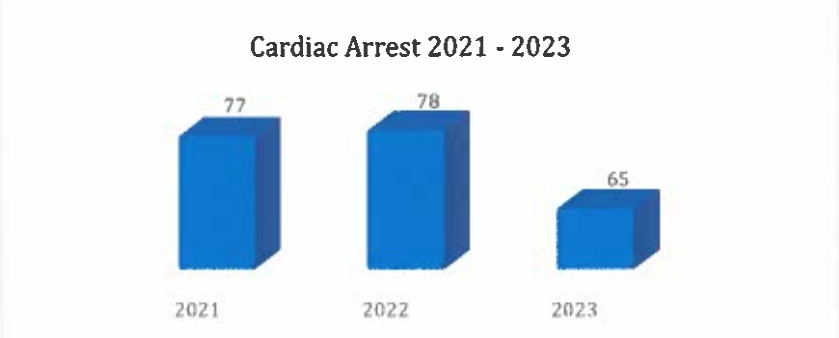


Source: COMPdata Informatics

Cardiac Arrest

Cases of dysrhythmia and cardiac arrest at Lee County area hospitals increased from 77 in 2021 to 78 in 2022, then decreased to 65 in 2023 (Figure 52).

Figure 52

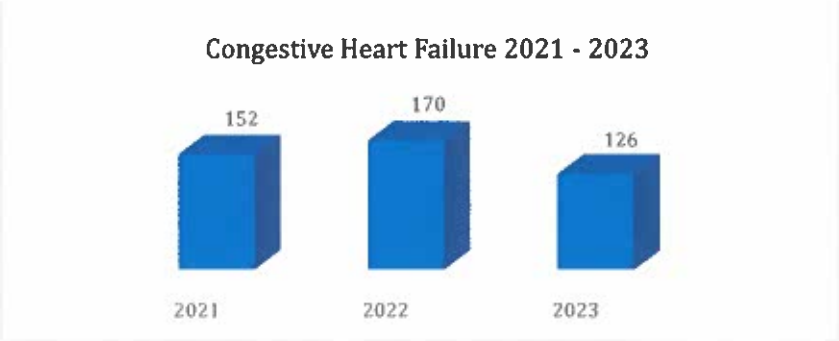


Source: COMPdata Informatics

Heart Failure

The number of heart failure treated patients at Lee County area hospitals increased from 152 in 2021 to 170 in 2022, then decreased to 126 in 2023 (Figure 53).

Figure 53



Source: COMPdata Informatics

Myocardial Infarction

The number of cases treated for myocardial infarction at area hospitals in Lee County decreased from 120 in 2021 to 103 in 2023 (Figure 54).

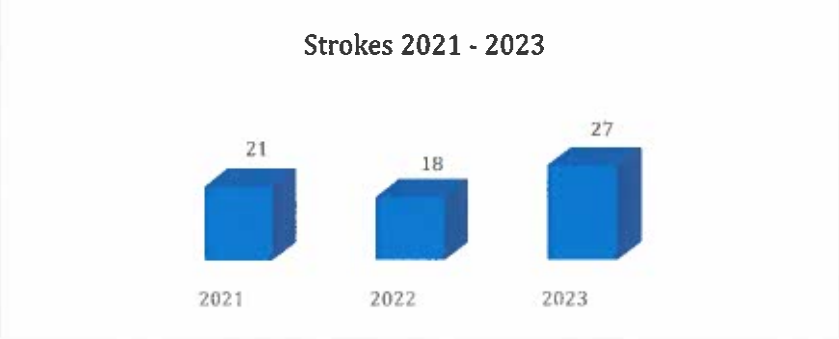
Figure 54

Source: COMPdata Informatics

Strokes

The number of stroke cases treated at Lee County area hospitals fluctuated between 2021 and 2023. Cases decreased from 21 in 2021 to 18 in 2022. The number of cases then increased to 27 in 2023 (Figure 55).

Figure 55



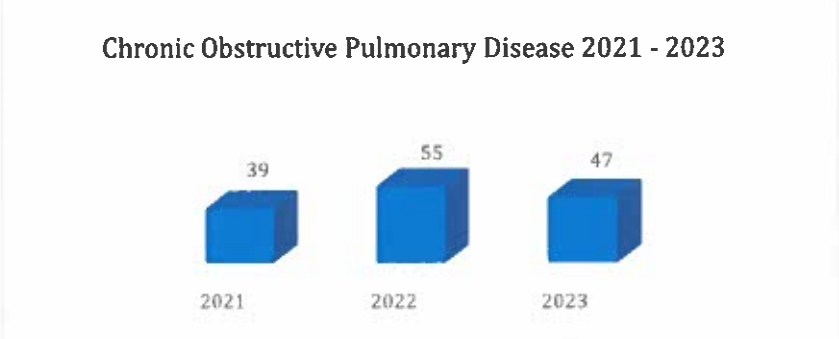
Source: COMPdata Informatics

4.4 Respiratory

Importance of the Measure: Diseases of the respiratory system include acute upper respiratory infections such as influenza, pneumonia, bronchitis, asthma, emphysema, and Chronic Obstructive Pulmonary Disease (COPD). These conditions are characterized by breathlessness, wheezing, chronic coughing, frequent respiratory infections, and chest tightness. Many respiratory conditions can be successfully controlled with medical supervision and treatment. However, children and adults who do not have access to adequate medical care are likely to experience repeated serious episodes, trips to the emergency room and absences from school and work. Hospitalization rates illustrate the worst episodes of respiratory diseases and serve as a proxy measure for inadequate treatment.

Treated cases of COPD at Lee County area hospitals increased from 39 in 2021 to 55 in 2022, then decreased to 47 in 2023 (Figure 56).

Figure 56



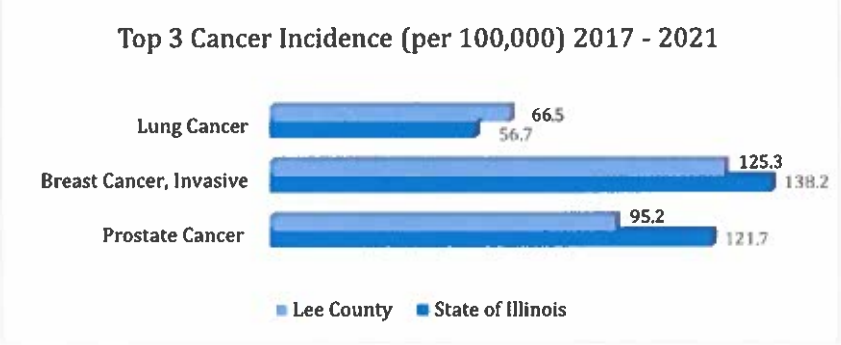
Source: COMPdata Informatics

4.5 Cancer

Importance of the Measure: Cancer is caused by the abnormal growth of cells in the body, and many causes of cancer have been identified. Generally, each type of cancer has its own symptoms, outlook for cure, and methods for treatment. Cancer is one of the leading causes of death in Lee County.

For the top three prevalent cancers in Lee County, comparisons are illustrated in the graph that follows (Figure 57). Specifically, lung cancer rates are higher than the State of Illinois average, while breast cancer and prostate cancer rates are lower than the State of Illinois average. Note that 2021 is the most recent year of data.

Figure 57



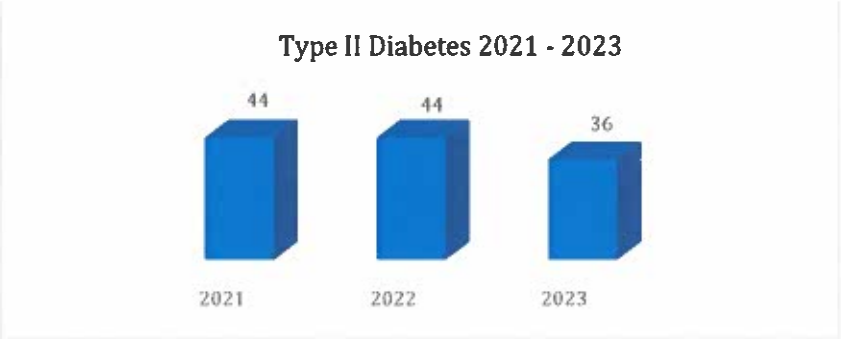
Source: Illinois Department of Public Health

4.6 Diabetes

Importance of the Measure: Diabetes is the leading cause of kidney failure, adult blindness, and amputations and it is a leading contributor to strokes and heart attacks. It is estimated that 90-95% of individuals with diabetes have Type II diabetes (previously known as adult-onset diabetes), while only 5-10% of individuals with diabetes have Type I diabetes (previously known as juvenile diabetes).

Inpatient cases of Type II diabetes from Lee County have decreased between 2021 (44 cases) and 2023 (36 cases) (Figure 58).

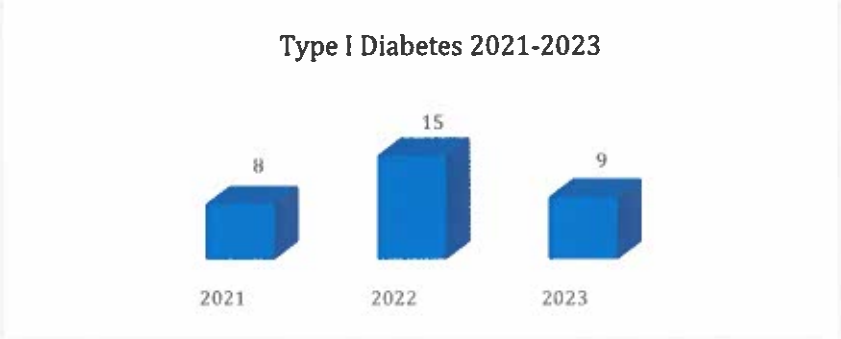
Figure 58



Source: COMPdata Informatics

Inpatient cases of Type I diabetes in Lee County show a slight overall increase from 2021 to 2023 with a spike in 2022 (Figure 59). Note that hospital-level data only show hospital admissions and do not reflect out-patient treatments and procedures.

Figure 59



Source: COMPdata Informatics

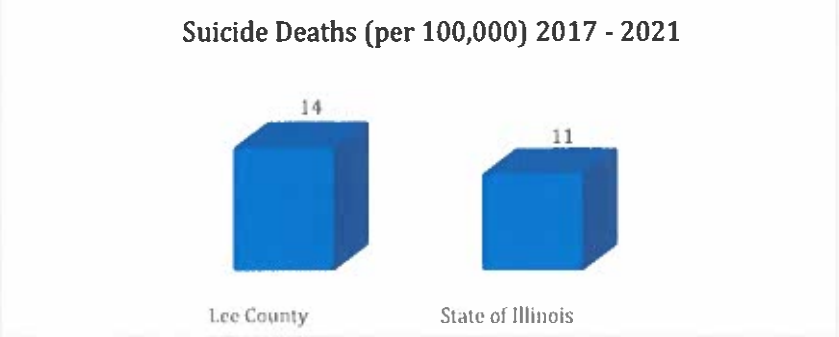
4.7 Injuries

Importance of the Measure: Suicide is intentional self-harm resulting in death. These injuries often indicate serious mental health problems requiring the treatment of other trauma-inducing issues.

Suicide

The number of suicides in Lee County indicates a higher incidence compared to the State of Illinois averages, with approximately 14 per 100,000 people in Lee County from 2017 to 2021 (Figure 60).

Figure 60



Source: Illinois Department of Public Health

4.8 Mortality

Importance of the Measure: Presenting data that focuses on causes of mortality provides an opportunity to define and quantify which diseases are causing the most deaths.

The leading causes of death in the State of Illinois and Lee County are similar as a percentage of total deaths in 2022. Diseases of the heart are the cause of 25.1% of deaths, cancer is the cause of 20.2% of deaths, and COVID-19 is the cause of 4.1% of deaths in Lee County (Table 1).

Table 1

Top 5 Leading Causes of Death for all Races by County & State of Illinois, 2022

Rank	Lee County	State of Illinois
1	Diseases of Heart (25.1%)	Diseases of Heart (21.8%)
2	Malignant Neoplasm (20.2%)	Malignant Neoplasm (19.2%)
3	COVID-19 (4.1%)	Accidents (6.1%)
4	Stroke (4.1%)	COVID-19 (5.8%)
5	Cerebrovascular Disease (4.1%)	Cerebrovascular Disease (5.4%)

Source: Illinois Department of Public Health

4.9 Key Takeaways from Chapter 4

- ✓ OVERWEIGHT TOPS THE LIST OF SELF-IDENTIFIED HEALTH ISSUES, FOLLOWED BY DEPRESSION/ANXIETY.
- ✓ LUNG CANCER RATES ARE SLIGHTLY HIGHER THAN STATE OF ILLINOIS AVERAGES.
- ✓ SUICIDE RATES ARE HIGHER THAN STATE OF ILLINOIS AVERAGES.
- ✓ HEART DISEASE AND CANCER ARE THE LEADING CAUSES OF MORTALITY.

CHAPTER 5 OUTLINE

5.1 Perceptions of Health Issues
5.2 Perceptions of Unhealthy Behavior
5.3 Perceptions of Issues with Well Being
5.4 Summary of Community Health Issues
5.5 Community Resources
5.6 Significant Needs Identified and Prioritized

CHAPTER 5: PRIORITIZATION OF HEALTH-RELATED ISSUES

In this chapter, the most critical health-related needs in the community are identified. To accomplish this, community perceptions of health issues, unhealthy behaviors, and issues related to well-being were first considered. Key takeaways from each chapter were then used to identify important health-related issues in the community. Next, a comprehensive inventory of community resources was completed, and finally, the most significant health needs in the community were prioritized.

Specific criteria used to identify these issues included: (1) magnitude in the community; (2) severity in the community; and (3) potential for impact to the community.

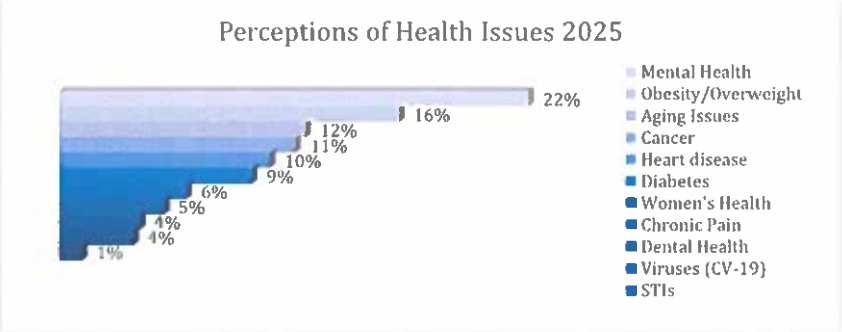
5.1 Perceptions of Health Issues

The CHNA survey asked respondents to rate the three most important health issues in the community from 11 different options.

The highest-rated health issues were mental health (22%) and obesity (16%) (Figure 61).

Note that perceptions of the community were accurate in some cases. For example, mental health issues are significantly increasing, and cancer is a leading cause of death. The survey respondents accurately identified these as important health issues. However, some perceptions were inaccurate. For instance, while heart disease is a leading cause of mortality, it is ranked relatively low.

Figure 61

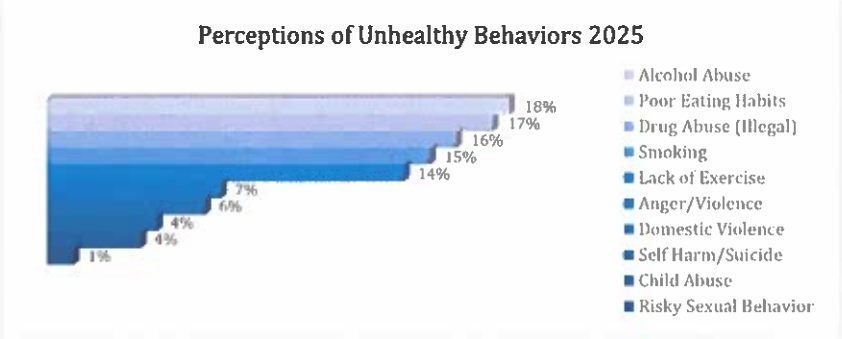


Source: CHNA Survey

5.2 Perceptions of Unhealthy Behaviors

Respondents were asked to select the three most important unhealthy behaviors in the community out of a total of 10 choices. The highest rated unhealthy behaviors are alcohol abuse (18%), poor eating habits (17%), drug abuse (illegal) (16%), smoking (15%), and lack of exercise (14%) (Figure 62).

Figure 62



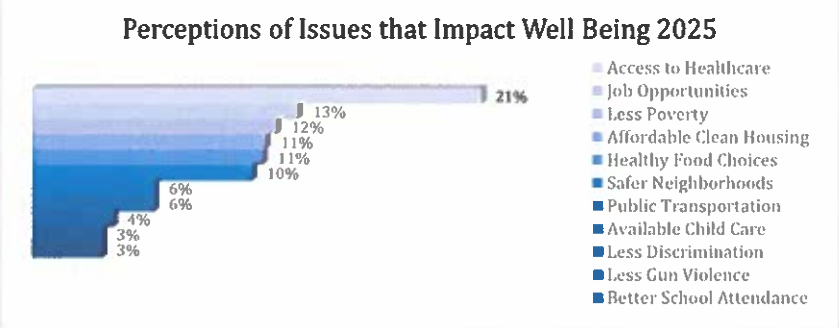
Source: CHNA Survey

5.3 Perceptions of Issues Impacting Well Being

Respondents were asked to select the three most important issues impacting well-being in the community from a total of 11 choices.

The highest-rated issue impacting well-being was access to healthcare (21%) (Figure 63). Access to healthcare was significantly higher than other categories based on t-tests between sample means.

Figure 63



Source: CHNA Survey

5.4 Summary of Community Health Issues

Based on the findings from the previous analyses, a chapter-by-chapter summary of key takeaways is used to provide a foundation for identifying the most important health-related issues in the community. Considerations for identifying key takeaways include magnitude in the community, strategic importance to the community, existing community resources, potential for impact, and trends and future forecasts.

Demographics (Chapter 1) - Three factors were identified as the most important areas of impact from the demographic analyses:

- Population decreased
- Population over age 65 increased
- Single female head-of-house-household represents 27% of the population

Prevention Behaviors (Chapter 2) - Four factors were identified as the most important areas of impact from the chapter on prevention behaviors:

- Not seeking medical care
- Prostate screening is relatively low
- Exercise and healthy eating behaviors
- Depression and stress/anxiety

Symptoms and Predictors (Chapter 3) - Four factors were identified as the most important areas of impact from the chapter on symptoms and predictors:

- Vaping and marijuana among young people
- Obesity
- Risk factors for heart disease
- Opioid use

Morbidity and Mortality (Chapter 4) - Four factors were identified as the most important areas of impact from the chapter on morbidity/mortality behaviors:

- Overweight and depression/anxiety
- Lung cancer
- Suicide
- Heart disease and cancer are the leading causes of mortality

Potential Health-Related Needs Considered for Prioritization

Before the prioritization of significant community health-related needs was performed, results were aggregated into 7 potential categories. Based on similarities and duplication, the 7 potential areas considered are:

- **Aging Issues**
- **Access to Healthcare**
- **Healthy Behaviors – Nutrition and Exercise**
- **Behavioral Health, Including Depression, Anxiety/Stress, Suicide**
- **Obesity**
- **Substance Use, Particularly Misuse of Prescription Medication**
- **Cancer - Lung**

5.5 Community Resources

After summarizing potential categories for prioritization in the Community Health Needs Assessment, a comprehensive analysis of existing community resources was performed to identify the efficacy to which these 7 health-related areas were being addressed. A resource matrix can be seen in APPENDIX 4. RESOURCE MATRIX relating to the 7 health-related issues.

There are numerous forms of resources in the community. They are categorized as recreational facilities, county health departments, community agencies, and area hospitals/clinics. A detailed list of community resources and descriptions appears in APPENDIX 5. DESCRIPTION OF COMMUNITY RESOURCES.

5.6 Significant Needs Identified and Prioritized

In order to prioritize the previously identified dimensions, the collaborative team considered health needs based on: (1) magnitude of the issues (e.g., what percentage of the population was impacted by the issue); (2) severity of the issues in terms of their relationship with morbidities and mortalities; (3) potential impact through collaboration.

Using a modified version of the Hanlon Method (as seen in APPENDIX 6: PRIORITIZATION METHODOLOGY), the collaborative team identified two significant health needs and considered them equal priorities:

- **Behavioral Health – Mental Health**
- **Access to Healthcare**

BEHAVIORIAL HEALTH – MENTAL HEALTH

MENTAL HEALTH. The CHNA survey asked respondents to indicate prevalence of specific issues, namely depression and stress/anxiety. Of respondents, 45% indicated they felt depressed in the last 30 days and 48% indicated they felt anxious or stressed in the last 30 days. Depression tends to be rated higher by those with lower income and those living in an unstable housing environment. Stress and anxiety tend to be rated higher for younger people, women, and those living in an unstable housing environment. Respondents were also asked if they spoke with anyone about their mental health in the last year. Of respondents, 49% indicated that they spoke to someone, the most common response was to family/friends (44%). In regard to self-assessment of overall mental health, 20% of respondents stated they have poor overall mental health. In the 2025 CHNA survey, respondents indicated that mental health was the most important health issue (22%).

ACCESS TO HEALTHCARE

PRIMARY SOURCE OF HEALTHCARE. The CHNA survey asked respondents to identify their primary source of healthcare. Four different options were presented: clinic or doctor's office, urgent-care facility, did not seek medical treatment, and emergency department. The most common response for source of medical care was clinic/doctor's office, chosen by 66% of survey respondents. This was followed by urgent care (22%), not seeking medical attention (10%), and the emergency department at a hospital (2%). Note that not seeking healthcare when needed is more likely to be selected by men. Selection of an emergency department as the primary source of healthcare did not have any significant correlates.

ACCESS TO MEDICAL CARE, PRESCRIPTION MEDICATION, DENTAL CARE, AND MENTAL-HEALTH COUNSELING. In the CHNA survey, respondents were asked, "In the past year, was there a time when you needed care but were not able to get it?" Access to four types of care were assessed: medical care, prescription medication, dental care, and counseling. Survey results showed that 18% of the population did not have access to medical care when needed; 21% did not have access to prescription medication when needed; 17% did not have access to dental care when needed; and 15% did not have access to counseling when needed. The leading causes of not getting access to care when needed were cost and too long of a wait.

Attachment 12-F

221

Attachment 12-F

Rockville

Schmelling Construction Co.

Larson & Darby Group
Architecture Engineering Interiors

222

BASEMENT FLOOR PLAN

Rockville
Schmelling
Larson & Darby Group
Architecture Engineering Interiors
FIRST FLOOR PLAN - ENLARGED
224
LDG PLANS
8

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068

March 3, 2026

Dear Karen Tracy,

On behalf of the City of Rochelle, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

RCH plays a critical role as a trusted, accessible, and patient-centered healthcare provider for residents of Rochelle and the surrounding rural communities. As patient needs evolve and demand increases, the hospital requires modernized facilities and updated clinical spaces to continue delivering safe, efficient, and exceptional care. The proposed improvements will directly address these needs.

Improved Access to Care
Enhancing emergency, convenient care, radiology, and laboratory services will significantly expand access for patients who rely on timely diagnostics, urgent evaluations, and efficient care pathways. These upgrades will reduce wait times, increase service capacity, and allow more patients to receive care close to home instead of traveling to distant hospitals.

Improved Quality of Care and Patient Outcomes
By modernizing clinical environments and integrating updated technology, RCH will strengthen its ability to provide efficient emergency care and high-quality diagnostic services. Emergency response, rapid testing and early detection are directly linked to better

patient outcomes. This project will ensure that clinicians have the tools and space needed to deliver the highest standards of care.

Enhanced Patient Throughput and Operational Efficiency
Updated layouts, expanded treatment areas, and streamlined workflows will improve patient movement through each department, reduce bottlenecks, enhance safety, and support a more efficient use of staff resources. These gains are essential for meeting growing demand and supporting a positive patient experience.

Securing the Long-Term Viability of the Hospital
For a rural community, the stability of the local hospital is vital to the region's health, economy, and resilience. This capital project is not just a facilities improvement—it's a long-term investment in ensuring that Rochelle Community Hospital remains a strong, sustainable healthcare anchor for generations to come.

For these reasons, I offer my full support for RCH's capital project and recognize the profound and lasting impact this investment will make on the health and well-being of our community.

Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Jenny Thompson

Jenny Thompson
Director of Community Engagement/Assistant to the City Manager
City of Rochelle
jthompson@rochelleil.us

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068

March 3, 2026

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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Sam Tesreau
Interim City Manager
City of Rochelle
stesreau@rochelleil.us

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026
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Sincerely,

Michelle J Pease

Michelle Pease
Community Development Director
City of Rochelle
mpease@rochelleil.us

DISTRICT OFFICE:
101 WEST FIRST STREET
SUITE 501
DIXON, IL 61021
PH: 815-561-3690

CAPITOL OFFICE:
221-N STRATTON BUILDING
SPRINGFIELD, IL 62706
PH: 217-782-0535

BRADLEY J. FRITTS
STATE REPRESENTATIVE
74TH DISTRICT

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of Illinois House District 74, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Thank you for your consideration.

Thank you for your time and consideration of this important matter. Please feel free to reach out to my office with questions by phone at 815-561-3690 or by email at Fritts@ILHouseGOP.org.

Sincerely,

Bradley J. Fritts

State Representative Bradley J. Fritts
District 74

Rochelle Area
COMMUNITY FOUNDATION

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of the Rochelle Area Community Foundation, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

RCH plays a critical role as a trusted, accessible, and patient-centered healthcare provider for residents of Rochelle and the surrounding rural communities. As patient needs evolve and demand increases, the hospital requires modernized facilities and updated clinical spaces to continue delivering safe, efficient, and exceptional care. The proposed improvements will directly address these needs.

Improved Access to Care
Enhancing emergency, convenient care, radiology, and laboratory services will significantly expand access for patients who rely on timely diagnostics, urgent evaluations, and efficient care pathways. These upgrades will reduce wait times, increase service capacity, and allow more patients to receive care close to home instead of traveling to distant hospitals.

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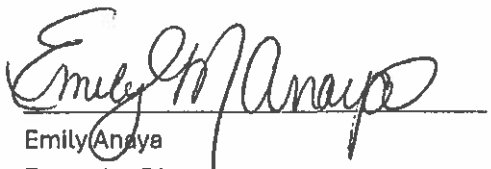
For these reasons, I offer my full support for RCH's capital project and recognize the profound and lasting impact this investment will make on the health and well-being of our community.

Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,



Emily Anaya
Executive Director
Rochelle Area Community Foundation
director@rochellefoundation.org

Rochelle Fire Department
401 5th Ave.
Rochelle, IL 61068

David W. Sawlsville
Fire Chief
Phone: (815) 562-2121

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,
On behalf of the Rochelle Fire Department, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.
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David Sawlsville
Fire Chief
Rochelle Fire Department
dsawlsville@rochelleil.us

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
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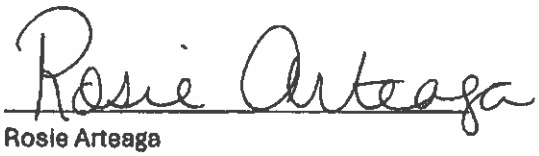

Rosie Arteaga
City Council
City of Rochelle

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rchp.net/815.562.2480

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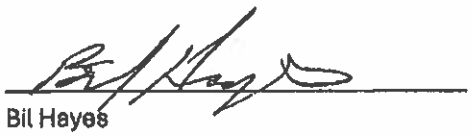

Bil Hayes
City Council
City of Rochelle

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rchs.net/815.562.2480

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Sincerely,

Kate Shaw-Dickey
City Council
City of Rochelle

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2460

March 3, 2026

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Sincerely,

Dan McDermott
City Council
City of Rochelle

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

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Sincerely,

Tom McDermott
City Council
City of Rochelle

HOPE
Opening Doors to a Safe and Peaceful Future
P.O. Box 131 • Rochelle, IL 61068

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of HOPE of Ogle County, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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P.O. Box 131 • Rochelle, IL 61068

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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Rebecca Laudati
Executive Director
HOPE of Ogle County
rlaudati@hopedv.org

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of Premier Health Consultants Inc, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Dr. Cullath
Owner/Hospitalist
Premier Health Group
sathishch1@gmail.com

March 3, 2026

Karen Tracy

Chief Executive Officer

Rochelle Community Hospital

900 North Second Street

Rochelle, IL 61068

Dear Ms. Tracy,

On behalf of Ridge Ambulance Service, I am pleased to formally express our strong support for the capital improvement project at Rochelle Community Hospital. This initiative to enhance and modernize the Emergency Department, Convenient Care, Radiology Department, and Laboratory Services represents a vital investment in strengthening regional access to high-quality healthcare and ensuring the long-term vitality of this essential community institution.

Rochelle Community Hospital remains a cornerstone of healthcare for Rochelle and surrounding rural areas. As patient volumes grow and care demands evolve, updating clinical spaces and diagnostic capabilities is essential to deliver safe, efficient, and patient-centered services.

The proposed enhancements will expand timely access to urgent evaluation and rapid diagnostics—critical for the patients we serve daily through emergency transports. These upgrades are anticipated to reduce wait times, boost capacity, and decrease the need for out-of-community transfers, thereby improving care continuity and convenience.

Modernized facilities and technology will empower healthcare teams to provide faster assessments, timely testing, and earlier interventions, all of which contribute to better patient outcomes. Optimized layouts, expanded treatment areas, and streamlined workflows will also improve throughput, ease operational bottlenecks, and make more effective use of staff resources—benefits that directly support a positive patient experience amid rising demand.

For rural communities like ours, a strong local hospital is fundamental to health, economic stability, and resilience. This project is more than a facility upgrade; it is a lasting commitment to keeping Rochelle Community Hospital as a sustainable, trusted anchor for generations ahead.

Ridge Ambulance Service offers its full and unequivocal support for this important initiative. We deeply value our ongoing collaboration with the hospital and recognize the profound, positive impact these improvements will have on the communities we both serve.

Thank you for your leadership in advancing healthcare in our region. Please feel free to contact me at any time if additional information or perspective would be useful.

Respectfully,

Steve Probst

Rochelle Station Supervisor

Ridge Ambulance Service

sprobst@ridgeems.com

FLAGG-ROCHELLE Public Library District

810 Fourth Avenue • Rochelle, Illinois 61068-1612
815-562-3431 • Fax: 815-562-8432

Kefen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
Ktracy@rchs.net/815.562.2480

March 4, 2026

Dear Kefen Tracy,

On behalf of the Flagg-Rochelle Public Library, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Sarah K. Flanagan
Director
Flagg-Rochelle Public Library
sarahf@flaggrochellepubliclibrary.org

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

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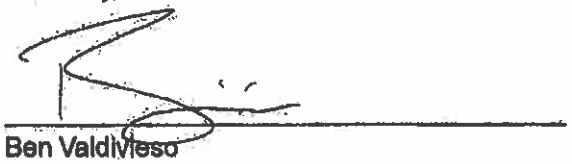

Ben Valdivieso
City Council Member
Rochelle City Council
bvaldivieso@rochelleil.us

Karen Tracy Chief Executive Officer Rochelle Community Hospital 900 North Second Street

Rochelle, IL 61068 ktracy@rcha.net/815.562.2480

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420 North 6th Street
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www.cityofrochelle.net

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support a more efficient use of staff resources. These gains are essential for meeting growing demand and supporting a positive patient experience.

Securing the Long-Term Viability of the Hospital For a rural community, the stability of the local hospital is vital to the region's health, economy, and resilience. This capital project is not just a facilities improvement—it's a long-term investment in ensuring that Rochelle Community Hospital remains a strong, sustainable healthcare anchor for generations to come.

For these reasons, I offer my full support for RCH's capital project and recognize the profound and lasting impact this investment will make on the health and well-being of our community.

Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Mayor John Bearrows
City of Rochelle
jbearrows@rochelleil.us

OSF HEALTHCARE

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of OSF HealthCare, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Sincerely,

AJ Querciagrossa

AJ Querciagrossa
Chief Executive Officer - Western Region
OSF HealthCare
august.j.querciagrossa@osfhealthcare.org

ROCHELLE PUBLIC SCHOOLS

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net / 815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of the Rochelle School Districts, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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On top of all of this, the Rochelle Community Hospital has been an active partner in programming, education, and offerings for our students and parents in joint efforts to improve the lives and overall health of our community's students and families.

For these reasons, I offer my full support for RCH's capital project and recognize the profound and lasting impact this investment will make on the health and well-being of our community.

Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Jason Harper
Superintendent of the Rochelle Schools
jharper@rthsd212.org / 815-562-4161

401 Cherry Ave, Rochelle, IL 61068
Office (815) 562-5050 Fax (815) 561-7012
www.hubcityseniorcenter.com

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of the Hub City Senior Center, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Attachment 12-G

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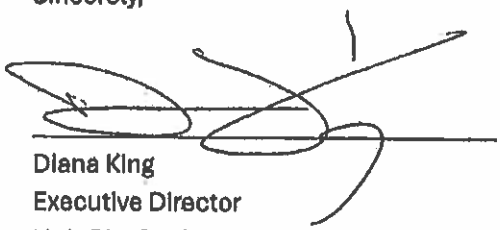
Sincerely,



Diana King
Executive Director
Hub City Senior Center
hubcityseniors@gmail.com

ROCHELLE
ILLINOIS
CHAMBER OF COMMERCE

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480
March 3, 2026

Dear Karen Tracy,

On behalf of the Rochelle Chamber of Commerce, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Tricia Herrera

Executive Director

Rochelle Chamber of Commerce

rochellechamber@gmail.com

SINNISSIPPI CENTERS
Together we inspire wellness

Administrative offices
325 Illinois Route 2 Dixon, IL 61021

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of Sinnissippi Centers, Inc., I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Tammy Stewart, Chief Clinical Officer
Sinnissippi Centers, Inc.

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of Reagan Mass Transit, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

Greg Gates
Executive Director
Reagan Mass Transit
ggates@reaganmtd.org

Prevent • Promote • Protect

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of the Ogle County Public Health Department, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Sincerely,

Melissa Spangler, MHA, BA
Administrator
Ogle County Public Health Department
mspangler@oglecountyil.gov

Karen Tracy
Chief Executive Officer
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
ktracy@rcha.net/815.562.2480

March 3, 2026

Dear Karen Tracy,

On behalf of Emergency Physician Staffing Solutions, I am writing to express my strong support for Rochelle Community Hospital's (RCH) capital project to enhance and modernize its Emergency Department, Convenient Care, Radiology Department, and Laboratory Services. This investment is vital to strengthening access to high-quality healthcare for our region and ensuring the long-term sustainability of an essential community institution.

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Sincerely,

Chris Troxell

Chris Troxell
Business Manager
Emergency Physician Staffing Solutions
christroxell@epsserdoc.com

Attachment 13
Alternatives

The Applicant undertook a comprehensive planning process that included a detailed assessment of the current and projected needs of the hospital and the community it serves. Multiple alternatives were evaluated for feasibility, cost-effectiveness, operational impact, and long-term sustainability. Based on this analysis, the Applicant determined that the proposed project most effectively addresses identified needs and represents the most appropriate and efficient use of hospital resources.

1. Larger-Scale Replacement or Comprehensive Redevelopment (Rejected)

A larger-scale project, including a comprehensive hospital replacement or broad campus redevelopment, was evaluated. This approach would address multiple space, infrastructure, and Mechanical, Electrical, and Plumbing ("MEP") deficiencies across the campus simultaneously and could fully modernize the facility while providing maximum long-term flexibility. Preliminary cost estimates ranged from approximately $70 million for a new greenfield facility to approximately $77 million for a phased complete replacement on the existing campus.

Although RCH could potentially finance a project of this magnitude, this alternative was rejected because it was not a prudent or cost-effective investment relative to the hospital's identified needs. The extensive scope and level of capital investment required would exceed what is necessary to address current and anticipated service needs and would not represent an efficient use of financial resources. In addition, the scale and duration of construction would create significant operational disruption. Accordingly, a full replacement or campus-wide redevelopment was determined to be disproportionate to RCH's needs and less efficient than the proposed project.

2. Renovate Existing Space Without New Construction (Rejected)

Renovating existing hospital space without constructing a new addition was considered as a potentially lower-cost alternative that would reduce the extent of new construction and allow for selected cosmetic and functional improvements.

This alternative was rejected because it would not adequately or efficiently address RCH's most critical operational, clinical, and infrastructure challenges. Many existing spaces — particularly within older buildings — are constrained by obsolete layouts and aging MEP systems that limit functionality and adaptability. Renovation alone would not provide sufficient space to alleviate emergency department ("ED") crowding, accommodate increasing emergency behavioral health patient visits, or support expanded and modernized diagnostic services.

Further, extensive renovation of older structures could trigger additional regulatory and code compliance requirements, increasing costs without providing commensurate long-term benefit. While this alternative would involve a lower initial capital investment, which was not pursued as the alternative was rejected, it would defer essential improvements and likely result in higher long-term costs and less efficient remediation, making it less cost-effective and sustainable than the proposed project.

3. Maintain Status Quo/Do Nothing (Rejected)

This Do-Nothing alternative was rejected because it fails to address significant and growing operational, clinical, and infrastructure deficiencies of the existing hospital campus. Much of RCH's physical plant and core infrastructure systems have exceeded their useful life and require major upgrades or replacement. Persistent space constraints, increasing demand for emergent behavioral health services, outdated diagnostic areas and equipment, building code and accessibility deficiencies, and ongoing wayfinding and access challenges would remain unaddressed and are expected to worsen over time.

Maintaining existing conditions would also increase regulatory and compliance risk, reduce operational efficiency, and negatively affect staff workflow, patient access, safety, and satisfaction. Over time, continued inaction would compromise RCH's ability to deliver care consistent with current standards and to respond effectively to evolving community needs.

While this alternative would require no immediate capital expenditure, it would defer essential capital improvements, resulting in higher long-term costs and less cost-effective remediation.

4. Proposed Project (Preferred/Selected Project)

The proposed project was selected as the preferred alternative because it represents the most cost-efficient and balanced approach to meeting RCH's current and anticipated future needs while maximizing the value of existing assets. Although the project requires a meaningful capital investment and will result in temporary operational disruption during construction, it avoids the substantially higher cost, complexity, and risk associated with full hospital replacement.

The proposed project directly addresses critical functional limitations and infrastructure deficiencies, aligns existing services with current standards of care, improves overall efficiency, and ensures compliance with applicable building codes, accessibility requirements, and environmental regulations. Collectively, these enhancements will modernize essential hospital infrastructure, strengthen patient access and safety, and position RCH to meet the evolving healthcare needs of the community in a financially responsible and sustainable manner, both now and in the future. The estimated project costs are $48,579.513.

Attachment 14 – Size of Project – 1110.120(a)

The project has been designed to meet all applicable state standards for size, while also meeting the clinical needs and operations associated with providing the highest quality of care to the RCH's patients and complying with applicable licensing standards of the Illinois Department of Public Health. For efficiency purposes and cost control, the Applicant has designed the clinical service areas to be smaller than the maximums allowed under the state standards. As reflected in the table below, the proposed gross square footage does not exceed state standards, is necessary, and is not excessive.

Although the state has not established square footage standards for urgent care/convenient care departments or laboratories, the proposed square footage for the relocated departments reflects a minimal increase in space compared to the existing departments and is not excessive.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF***	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
Clinical				
Emergency Department	7184 dgsf	900 dgsf/treatment station x 10 = 9000 dgsf	-1816 dgsf	**yes**
General Radiology	6851 dgsf**	1300 dgsf/Unit x 9 = 11,700sf	-4849 dgsf	**yes**
X-Ray	1205 dgsf	1300 dgsf/Unit x 2 = 2600 dgsf	-1395 dgsf	**yes**
Mammography	576 dgsf	900 dgsf/Unit	-324 dgsf	**yes**
Ultra-Sound	777 dgsf	900 dgsf/Unit	-123 dgsf	**yes**
CT Scan	988 dgsf	1800 dgsf/Unit	-812 dgsf	**yes**
MRI	1651 dgsf	1800 dgsf/Unit	-149 dgsf	**yes**
Nuclear Medicine	1217 dgsf	1600 dgsf/Unit	-383 dgsf	**yes**
DEXA	437 dgsf	1300 dgsf/Unit	-863 dgsf	**yes**
Lab	3485 dgsf	N/A	N/A	**N/A**
Convenient Care	2120 dgsf	N/A	N/A	**N/A**
Non-Clinical				
Administrative	9843 dgsf	N/A	N/A	**N/A**
Patient Reg/Circ/Staff/Loading Dock	14,893 dgsf	NA	NA	**NA**
Material Management	2802 dgsf	NA	NA	**NA**

*Includes circulation and ancillary support space

**Amount of square footage for entire Radiology Department.

Attachment 15 – Project Services Utilization – 1110.120(b)

Emergency Department

The proposed project entails the relocation and expansion of the existing Emergency Department ("ED") from six stations to ten stations, three of which will be specifically designed and equipped to safely treat patients experiencing mental health crises. Although projected ED utilization by the second year of operation does not meet the state standard of 2,000 visits per station per year, the additional stations are necessary to accommodate critical peak-demand periods, reduce ED wait times, and enhance RCH's ability to provide timely, safe, and effective emergency care. The need for this additional capacity is particularly important given the expected increase in behavioral health-related emergency visits over the next ten years.

Currently, ED volumes frequently require RCH to implement overflow strategies, including staging lower-acuity patients while awaiting transfer of patients requiring specialized services that cannot be provided onsite. These circumstances result in longer-than-optimal wait times for transfer and extended ED holds while appropriate placement is sought. On average, RCH treats more than 50 patients per month with a primary behavioral health diagnosis, representing a range of acuity levels. As a critical access hospital, RCH does not have the resources or capability to provide inpatient psychiatric care; consequently, patients experiencing acute mental health crises must often remain in the ED for extended periods while alternative inpatient placement is arranged at other facilities.

These prolonged waits and holds place significant strain on ED resources and impede timely triage and treatment for other emergency patients. Expansion to a ten-station ED will allow RCH to better manage peak volumes, expedite the triage process, and reduce delays associated with higher patient demand, thereby improving overall emergency care delivery for the community.

Dept./Service	Historical Utilization		Projected Utilization		State Standard	Meet Standard?
	2024	2025	Year 1 Post-Project Completion	Year 2 Post-Project Completion		
Emergency Department	8,697 visits	9,066 visits	10,825 visits	11,150 visits	2000 visits/station/year 2000 x 10 stations = 20,000 visits/year	No

Diagnostic/Interventional Radiology

RCH's existing radiology department currently has the following diagnostic and interventional radiology equipment: two x-ray units, one nuclear medicine unit, one mammography unit, one ultrasound unit, one CT scanner, one MRI, and one DEXA Scan machine. The proposed project does not involve an increase in the number of imaging units. Rather, the project includes replacement of an outdated nuclear medicine unit that cannot be accommodated within the physical constraints of the existing department.

As noted in Appendix B, the state utilization standards for Diagnostic and Treatment Services establish minimum procedure volumes required to justify the addition of more than one unit or piece of equipment. As reflected below, utilization for all imaging modalities meet applicable state standards, and projected utilization for general radiology will meet state standards by year 2 following project completion. The state standard for X-ray services is 8,000 procedures per unit per year to support more than one X-ray machine. RCH projects projected utilization of 8,940 procedures by year 2 of project completion.

Dept./Service	**Historical Utilization**		**Projected Utilization**		**State Standard to Justify Second Unit**	**Meet Standard?**
	2024	2025	Year 1 Post-Project Completion	Year 2 Post-Project Completion		
General Radiology/X-Rays	7498	7,783	8,765	8,940	8,000 procedures	Yes
Nuclear Medicine	74	175	209	215	2,000 visits/unit	Yes
Mammography	960	1,111	1,179	1,191	5,000 visits/unit	Yes
Ultrasound	2,305	2,273	2,714	2,795	3,100 visits/unit	Yes
CT	4,051	4,096	4,350	4,394	7,000 visits/unit	Yes
MRI	676	570	642	655	2,500 procedures	Yes
DEXA	262	276	311	317	1300 procedures	Yes

Convenient Care

Although there are no established utilization standards for convenient care or urgent care departments, the Applicant has included historical and projected utilization data below to demonstrate current use and anticipated demand.

Dept./Service	**Historical Utilization**		**Projected Utilization**		**State Standard**	**Meet Standard?**
	2024	2025	Year 1 Post-Project Completion	Year 2 Post-Project Completion		
Convenient Care	4,760 visits	5,610 visits	5,782 visits	6,013 visits	N/A	N/A

Attachment 31 – Clinical Service Areas Other than Categories of Service – 1110.270

The proposed project involves the relocation and modernization of select departments on the hospital campus, and, therefore, qualifies as a "Service Modernization" under Section 1110.270(a)(3) and (c).

To satisfy the HFSRB's criterion, applicants need to demonstrate the proposed project satisfies one of the following conditions:

(1) The project will result in replacement of equipment or facilities that have deteriorated and need replacement;[5]

(2) The project is necessary to expand diagnostic treatment, ancillary training, or other support services to meet patient service demand;[6] or

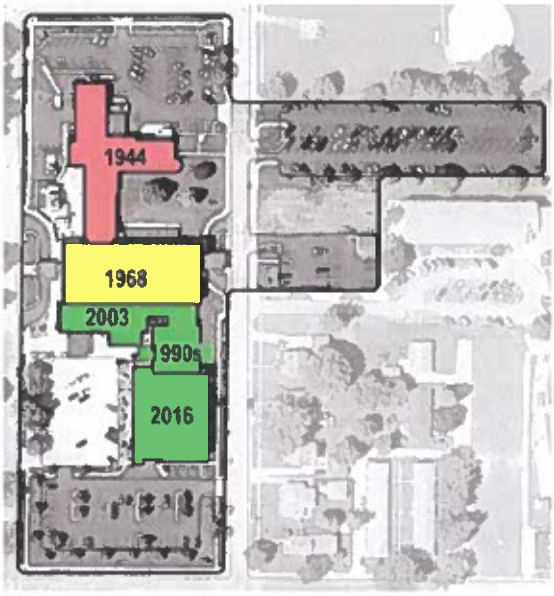
(3) Utilization.[7]
   a. For projects acquiring major medical equipment, documentation that the equipment will achieve or exceed applicable target utilization levels within 12 months of acquisition;
   b. For projects involving modernization of a service or facility, demonstration that utilization standards for the service are met or exceeded; or
   c. If no utilization standards exist, documentation of anticipated utilization based on incidence of disease, conditions treated, or population use rates.

This criterion is satisfied as the project will replace deteriorated facilities and infrastructure, constitutes a "necessary expansion" to address patient demand, and meets or is projected to meet the majority of applicable utilization standards.

The project represents a necessary and carefully planned modernization initiative that will address significant functional limitations and infrastructure deficiencies associated with RCH's aging hospital campus. The project will align existing services with current standards of care, improve operational efficiency, and ensure the facility is positioned to meet evolving community needs.

RCH was established in 1913 under the name Lincoln Hospital. The current hospital campus at 900 North Second Street was developed beginning in 1944 and has undergone multiple additions and expansions over the decades, including a 1968 expansion housing the Laboratory and Radiology departments, a 1990s expansion accommodating Convenient Care services, a 2003 addition for the existing Emergency Department ("ED"), and a medical office building constructed in 2016. As a result of these expansions spanning more than 80 years (see image below), building systems have been integrated across multiple construction vintages, creating ongoing challenges related to electrical, HVAC, fire suppression, and plumbing system compatibility and reliability.

[5] 77 Ill. Admin. Code § 1110.270(c)(1).
[6] 77 Ill. Admin. Code § 1110.270(c)(2).
[7] 77 Ill. Admin. Code § 1110.270(c)(3)(A)-(C).



In 2023, RCH engaged an independent consultant to evaluate its mechanical infrastructure. The assessment concluded that the majority of the hospital's infrastructure systems have exceeded their useful life and require major upgrades or replacement. The proposed project will proactively address these deteriorated conditions while ensuring compliance with current building codes, accessibility standards, and applicable environmental regulations, including asbestos abatement, building separation requirements, stair and ramp compliance, and installation of fire sprinkler systems. Collectively, these improvements will modernize critical hospital infrastructure, enhance patient safety and access, and ensure the long-term viability of the hospital facility.

The first phase of the project will focus on demolition of the 1944 portion of the hospital to allow for construction of a new structure housing the relocated ED, Radiology, Laboratory, and Convenient Care departments. A new basement level will be constructed to accommodate replacement boilers, water heaters, electrical infrastructure, and other mechanical equipment necessary to support hospital-wide operations. This new construction will enable RCH to right-size clinical spaces, fully integrate mechanical systems, and design departments in accordance with contemporary operational and regulatory requirements.

The project includes the relocation and expansion of the existing six-station ED to a ten-station ED that is appropriately sized to accommodate current utilization, projected demand, and the increasing need for behavioral health emergency services. Three of the ten ED stations will be designed and equipped to safely treat patients experiencing acute mental health crises. Although projected ED utilization by the second year following project completion does not meet the state standard of 2,000 visits per station per year (see Attachment 15), the additional stations are necessary to accommodate peak-demand periods, reduce ED wait times, and enhance RCH's ability to provide timely, safe, and effective emergency care. This need is particularly significant given the anticipated increase in behavioral health-related emergency visits over the next ten years.

Currently, ED volumes frequently require RCH to implement overflow strategies, including staging lower-acuity patients while awaiting transfer of patients requiring specialized services not available onsite. These conditions result in longer-than-optimal transfer wait times and extended ED holds while appropriate placement is sought. On average, RCH treats more than 50 patients per month with a primary behavioral health diagnosis encompassing varying acuity levels. As a critical access hospital, RCH lacks the resources to provide inpatient psychiatric care; therefore, patients experiencing acute mental health crises often remain in the ED for extended periods while alternative inpatient placement is arranged. These prolonged waits strain ED resources and impede timely triage and treatment of other emergency patients. Expansion to a ten-station ED will enable RCH to better manage peak volumes, expedite triage, and reduce delays associated with higher patient demand, thereby improving emergency care delivery.

To enhance emergency care delivery and maintain stroke readiness, the Radiology Department will be relocated adjacent to the ED to improve care coordination. The proposed project does not increase the number of imaging units; rather, it includes replacement of an outdated nuclear medicine unit that cannot be accommodated within the current department's physical constraints. As reflected in Attachment 15, all imaging modalities meet applicable state utilization standards, and projected utilization for general radiology will meet the state standard by the second year following project completion.

The Laboratory Department is currently located in a constrained space within the 1968 portion of the hospital and is functionally obsolete. Expansion of the Laboratory is urgently needed; however, the existing location cannot accommodate growth due to stringent laboratory requirements for temperature, humidity, and room pressure control, which the antiquated HVAC system cannot reliably maintain. Additionally, the Laboratory is bounded by the Radiology Department and a mechanical room, precluding physical expansion. The proposed project addresses these limitations by relocating the Laboratory to newly constructed basement space that is appropriately sized and designed with redundant HVAC systems to meet all air-handling requirements. Locating the Laboratory on a lower level will improve environmental stability. The expanded space will support additional testing equipment, reduce reliance on send-out testing, improve turnaround times, and enhance the patient experience. Increased equipment capacity will also provide backup capability for critical tests, minimizing downtime during routine maintenance and significantly improving employee safety, satisfaction, and working conditions.

Attachment 34 – Availability of Funds

Audited financial statements of the Applicant are attached and demonstrate that the Applicant is financially secure and possesses adequate unrestricted cash resources to fully fund the proposed project.

The Applicant is engaging in efforts to secure project funding through grants, gifts, and other community contributions. The Applicant was recently notified by Congressman Darin LaHood that its $4,000,000 funding request has been selected for consideration during the FY 2027 Appropriations process. To be selected for consideration, projects must have a federal nexus and meet various requirements to ensure only high-quality projects are requested and funded. A copy of the funding request from Congressman LaHood to the House Committee on Appropriations is included in Attachment 34.

Although the Applicant expects to receive supplemental funding through other similar gifts, grants, and contributions, offsetting a portion of the total project cost, the project is not dependent on such funding. The Applicant has the financial capacity to proceed with and complete the project using internal cash resources alone.

$48,579,513	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.
_____	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. g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$48,579,513	**TOTAL FUNDS AVAILABLE**

ROCHELLE COMMUNITY HOSPITAL
ASSOCIATION AND ITS AFFILIATES

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED APRIL 30, 2025 AND 2024

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ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
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INDEPENDENT AUDITORS' REPORT

Board of Trustees
Rochelle Community Hospital Association and its Affiliates
Rochelle, Illinois

Report on the Consolidated Financial Statements

Opinion

We have audited the accompanying consolidated financial statements of Rochelle Community Hospital Association and its Affiliates (the Hospital), which comprise the consolidated statements of financial position as of April 30, 2025 and 2024, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of April 30, 2025 and 2024, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Hospital and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Hospital's ability to continue as a going concern for one year after the date the consolidated financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Hospital's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The April 30, 2025 and 2024, consolidating information on pages 25 to 30 is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, changes in net assets, and cash flows of the individual entities, and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole. The schedule of community benefits information marked as "unaudited" and presented on page 31, which is the responsibility of management, is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has not been subjected to the auditing procedures applied in the audits of the consolidated financial statements and, accordingly, we do not express an opinion or provide any assurance on it.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

St. Louis, Missouri
July 29, 2025

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
APRIL 30, 2025 AND 2024

	2025	2024
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 27,751,875	$ 26,522,891
Assets Limited as to Use Under Bond Agreement, Held by Trustee	244,619	505,435
Temporary Investments	24,094,720	21,902,080
Patient Accounts Receivable	6,158,795	6,058,277
Estimated Receivables, Third-Party Payors	429,909	-
Inventories	394,350	415,892
Other Receivables	807,245	832,145
Prepaid Expenses and Other Assets	1,672,372	1,415,932
Total Current Assets	61,553,885	57,652,652
OTHER ASSETS		
Deferred Compensation Investments	248,504	151,701
Property and Equipment, Net	17,851,979	18,620,391
Financing Right-of-Use Assets	261,165	338,116
Operating Right-of-Use Assets	169,112	250,225
Total Other Assets	18,530,760	19,360,433
Total Assets	$ 80,084,645	$ 77,013,085
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable	$ 1,167,559	$ 637,265
Accrued Expenses	3,904,856	3,471,935
Estimated Liabilities, Third-Party Payors	-	382,705
Current Portion of Financing Lease Obligations	190,850	143,312
Current Portion of Operating Lease Obligations	67,213	80,224
Current Portion of Bonds Payable	239,036	525,036
Total Current Liabilities	5,569,514	5,240,477
LONG-TERM LIABILITIES		
Deferred Compensation Payable	241,466	145,189
Financing Long-Term Lease Obligations, Net	85,441	212,273
Operating Long-Term Lease Obligations, Net	107,671	174,884
Bonds Payable, Less Current Maturities	2,353,128	3,944,014
Total Long-Term Liabilities	2,787,706	4,476,360
Total Liabilities	8,357,220	9,716,837
NET ASSETS		
Net Assets Without Donor Restrictions	71,727,425	67,296,248
Total Liabilities and Net Assets	$ 80,084,645	$ 77,013,085

See accompanying Notes to Consolidated Financial Statements.

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED APRIL 30, 2025 AND 2024

	2025	2024
NET ASSETS WITHOUT DONOR RESTRICTIONS		
Operating Revenue:		
Patient Service Revenue	$ 52,814,394	$ 49,944,866
Other Revenue	557,938	398,601
Total Operating Revenue	53,372,332	50,343,467
Operating Expenses:		
Salaries and Wages	23,371,730	21,436,367
Employee Benefits	5,170,540	4,302,197
Purchased Services	10,611,822	9,919,196
Supplies, Drugs, Food and Other	7,300,992	6,487,775
Depreciation and Amortization	4,605,472	4,402,578
Interest	187,300	168,554
Insurance	590,449	569,700
Total Operating Expenses	51,838,305	47,286,367
INCOME FROM OPERATIONS	1,534,027	3,057,100
OTHER INCOME (EXPENSES)		
Other Investment Income	717,137	490,920
Gain (Loss) on Disposal of Assets	(4,197)	91,475
Income on Temporary Investments and Assets Limited as to Use	731,111	371,193
Unrealized Gain on Investments	1,453,099	2,248,746
Total Other Income	2,897,150	3,202,334
EXCESS OF REVENUES OVER EXPENSES	4,431,177	6,259,434
Net Assets - Beginning of Year	67,296,248	61,036,814
NET ASSETS - END OF YEAR	$ 71,727,425	$ 67,296,248

See accompanying Notes to Consolidated Financial Statements.

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED APRIL 30, 2025 AND 2024

	2025	2024
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Net Assets	$ 4,431,177	$ 6,259,434
Adjustments to Reconcile Increase in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation and Amortization	4,605,472	4,402,578
Amortization of Debt Issuance Cost	75,248	17,100
Interest Earned on Temporary Investments and Assets Limited as to Use	(731,111)	(371,193)
(Gain) Loss on Disposal of Assets	4,197	(91,475)
Unrealized Gain on Investments	(1,453,099)	(2,248,746)
Effects of Changes in Operating Assets and Liabilities:		
Patient Accounts Receivable	(100,518)	(346,792)
Other Current Assets	(209,109)	(196,883)
Accounts Payable, Accrued Expenses and Other Liabilities	963,215	(115,499)
Estimated Receivables and Liabilities, Third-Party Payors	(382,705)	282,622
Net Cash Provided by Operating Activities	7,202,767	7,591,146
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of Property and Equipment	(3,676,863)	(2,441,827)
Change in Temporary Investments and Assets Limited as to Use	(7,057)	147,390
Net Cash Used by Investing Activities	(3,683,920)	(2,294,437)
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments on Finance Lease Obligations	(166,737)	(141,569)
Payments on Bonds Payable	(1,952,134)	(525,037)
Net Cash Used by Financing Activities	(2,118,871)	(666,606)
NET INCREASE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	1,399,976	4,630,103
Cash, Cash Equivalents, and Restricted Cash - Beginning of Year	27,052,620	22,422,517
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - END OF YEAR	$ 28,452,596	$ 27,052,620
SUMMARY OF CASH, CASH EQUIVALENTS, AND RESTRICTED CASH		
Cash and Cash Equivalents	$ 27,751,875	$ 26,522,891
Cash in Assets Limited as to Use	244,619	505,435
Cash in Temporary Investments	26,193	24,294
Total Cash, Cash Equivalents, and Restricted Cash	$ 28,022,687	$ 27,052,620
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash Paid for Interest	$ 187,300	$ 168,554

See accompanying Notes to Consolidated Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Rochelle Community Hospital Association (a nonprofit corporation, the Association) was incorporated December 28, 1966, in the state of Illinois. The Association provides inpatient, outpatient, and emergency care services for residents of north central Illinois. Admitting physicians are primarily practitioners in the local area. The Association's fiscal year ends on April 30. Significant accounting policies followed by the Association are presented below.

Rochelle Community Hospital Foundation (a nonprofit corporation, the Foundation) was incorporated on May 21, 1990, in the state of Illinois for the purpose of obtaining and administering assets to support the operation of Rochelle Community Hospital Association. The Foundation's fiscal year ends on April 30.

Principles of Consolidation

The consolidated financial statements include the accounts of the Rochelle Community Hospital Association and Rochelle Community Hospital Foundation (collectively, the Hospital). All significant intercompany balances and transactions have been eliminated in the consolidation.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include all liquid investments with maturities of three months or less, when purchased, excluding amounts whose use is limited by board designation or restricted for a specific purpose by the donor or restricted for bond funds. Throughout the year, the Hospital may have amounts on deposit with financial institutions in excess of those insured by the FDIC. The Hospital has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk.

Patient Accounts Receivable and Allowance for Credit Losses

Patient accounts receivable consist of amounts due for the provision of health care services which are recorded in the accompanying consolidated statements of financial position at amortized cost at the net amount expected to be collected. In evaluating the collectability of patient accounts receivable, Management regularly reviews data and develops a loss rate to determine expected credit losses based on several factors including whether a patient has third-party payor coverage or is uninsured, the aging of receivables, historical collection and loss experience, current contract prices or claims paid data, and trends for each of its major payors sources of revenue. These estimates are adjusted for recoveries and any anticipated changes in trends, including significant changes in payor mix, economic conditions, or trends in federal and state governmental health care coverage.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Inventories

Inventories are stated at the lower of cost or net realizable value, cost determined on a first-in, first-out (FIFO) basis of accounting.

Temporary Investments

Temporary investments include mutual funds and certificates of deposit, which are considered short term in nature and are recorded at fair value as discussed in Note 14. Gains and losses, both realized and unrealized, on the mutual funds are included in increase in net assets without donor restrictions.

Impairment of Investments

Investment securities in general are exposed to risks, such as interest rate, credit and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the value of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the consolidated statement of financial position.

Assets Limited as to Use

Assets limited as to use include assets held by trustee under indenture agreements. Amounts required to meet current liabilities of the Hospital have been reclassified to current assets in the consolidated statement of financial position at April 30, 2025 and 2024.

Property and Equipment

Property and equipment acquisitions in excess of $5,000 are recorded at cost, if purchased. Any property and equipment acquired through a gift is recorded at fair market value on the date donated. Depreciation is provided over the estimated useful life of each class of depreciable asset, which ranges from three to forty years, and is computed using the straight-line method. The equipment under capital leases is depreciated using the straight-line method over the term of the leases, which ranges from three to five years. Interest cost incurred on borrowed funds during the period of construction of property is capitalized as a component of the cost of acquiring those assets. Expenditures for maintenance and repairs that do not extend the life of the applicable assets are expensed as incurred.

Long-Lived Assets

Management evaluates its long-lived assets for possible impairment whenever events or circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. Measurement of the amount of the impairment, if any, may be based on independent appraisals, established market values of comparable assets or estimates of future discounted cash flows expected to result from the use and disposition of the assets. The estimates of these future cash flows are based on assumptions and projections believed by management to be reasonable. These subjective judgments take into account assumptions about revenue and expense growth rates, patient volumes, changes in payor mix, regulations, and other factors.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Excess of Revenues Over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in net assets without donor restrictions which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading debt securities and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The Hospital follows the federal poverty guidelines and on an annual basis reviews and adjusts its charity care and uninsured discount policies accordingly.

Income Taxes

Rochelle Community Hospital Association and Rochelle Community Hospital Foundation are nonprofit corporations and have been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code and have been classified as other than a private foundation.

The Hospital files a Form 990 (Return of Organization Exempt from Income Tax) annually. When this return is filed, it is highly certain that some positions taken would be sustained upon examination by the taxing authorities, while others are subject to uncertainty about the merits of the position taken or the amount of the position that would ultimately be sustained. Examples of tax positions include such matters as the following: the tax-exempt status of the entity and various positions relative to potential sources of unrelated business taxable income (UBIT). UBIT is reported on Form 990T, as appropriate. The benefit of a tax position is recognized in the financial statements in the period during which, based on all available evidence, management believes that it is more likely than not that the position will be sustained upon examination, including the resolution of appeals or litigation processes, if any.

Tax positions are not offset or aggregated with other positions. Tax positions that meet the "more likely than not" recognition threshold are measured as the largest amount of tax benefit that is more than 50% likely to be realized on settlement with the applicable taxing authority.

The portion of the benefits associated with tax positions taken that exceeds the amount measured as described above is reflected as a liability for unrecognized tax benefits in the accompanying consolidated statements of financial position along with any associated interest and penalties that would be payable to the taxing authorities upon examination. Presently there are no ongoing income tax audits or unresolved disputes with tax authorities that the Hospital currently files or has filed with.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Advertising

The Hospital expenses advertising costs as incurred.

Risk Management

The Hospital is exposed to various risks of loss from lawsuits; theft of, damage to, and destruction of assets; business interruption; errors and omissions; medical malpractice; employee injuries and illnesses; natural disasters and employee health, dental, and accident benefits. See Note 9 – Self Insurance for a description of the employee health insurance coverage and Note 12 – Medical Malpractice Claims for a description of the professional liability insurance.

Regulatory Investigation

The U.S. Department of Justice, other federal agencies, and the Illinois Department of Public Aid routinely conduct regulatory investigations and compliance audits of health care providers. The Hospital is subject to these regulatory efforts. Management is currently unaware of any regulatory matters which may have a material effect on the Hospital's financial position or results from operation. However, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Donor-Restricted Gifts

Unconditional promises to give cash, grants, and other assets are reported at fair value at the date the promise is received or grant awarded. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts and grants are reported as net assets with donor restrictions if they are received with donor or grantor stipulations that limit the use of the assets. When donor- or grantor-stipulated time restrictions or purpose restrictions are met or accomplished, donor-restricted net assets are reclassified as net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restrictions for property and equipment additions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as contributions without donor restrictions in the consolidated statements of operations and changes in net assets.

Basis of Presentation

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

Net Assets Without Donor Restrictions – Include net assets available for use in general operations and not subject to donor (or certain grantor) restrictions. At times, the governing board can designate, from net assets without donor restrictions, net assets for a board-designated endowment or other purposes.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Basis of Presentation (Continued)

Net Assets With Donor Restrictions – Include net assets subject to donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Donor-imposed restrictions are released when a restriction expires, that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource has been fulfilled, or both.

Revenues are reported as increases in net assets without donor restrictions, unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in net assets without donor restrictions. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in net assets without donor restrictions, unless their use is restricted by explicit donor restriction or by law.

Leases

The Hospital determines if an arrangement is a lease at inception. Operating and financing leases are included in Right-of-Use Assets (ROU) and Long-Term Lease Obligations on the consolidated statements of financial position.

ROU assets represent the Hospital's right to use an underlying asset for the lease term and lease liabilities represent the Hospital's obligation to make lease payments arising from the lease. ROU assets and liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. Lease terms may include options to extend or terminate the lease when it is reasonably certain that the Hospital will exercise that option. Lease expense for operating lease payments is recognized on a straight-line basis over the lease term. The Hospital has elected to recognize payments for short-term leases with a lease term of 12 months or less as expense as incurred and these leases are not included as lease liabilities or right-of-use assets on the consolidated statements of financial position.

The individual lease contracts do not provide information about the discount rate implicit in the lease. Therefore, the Hospital has elected to use an estimation of its incremental borrowing rate determined using a period comparable with that of the lease term for computing the present value of lease liabilities.

Estimated Malpractice Costs

The provision for estimated medical malpractice claims (included in accrued expenses) includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Reclassifications

Certain reclassifications have been made to the 2024 consolidated financial statements to conform to the 2025 presentation. The reclassifications had no effect on the consolidated statements of financial position or operations and changes in net assets.

Subsequent Events

In preparing these consolidated financial statements, the Hospital has evaluated events and transactions for potential recognition or disclosure through July 29, 2025, the date the consolidated financial statements were available to be issued.

NOTE 2 LIQUIDITY AND AVAILABILITY

As of April 30, 2025 and 2024, the Hospital had working capital of $55,984,371 and $52,412,175, respectively.

Financial assets available for general expenditure within one year of the statement of financial position date consist of the following:

	2025	2024
Cash and Cash Equivalents	$ 27,751,875	$ 26,522,891
Accounts Receivable, Net	6,158,795	6,058,277
Temporary Investments	24,094,720	21,902,080
Current Portion of Assets Limited as to Use, Held by Trustee	244,619	505,435
Total	$ 58,250,009	$ 54,988,683

NOTE 3 ASSETS LIMITED AS TO USE AND INVESTMENTS

Assets limited as to use that are required for obligations classified as current liabilities, if any, are reported in current assets. Following is a summary of assets limited as to use at April 30:

	2025	2024
Under Bond Agreement – Held by Trustee	$ 244,619	$ 505,435

The composition of assets limited as to use and temporary investments at April 30 is as follows:

	2025	2024
Mutual Funds	$ 24,006,779	$ 21,877,786
Certificates of Deposit	61,748	-
Cash and Cash Equivalents	270,812	529,729
Total Assets Limited as to Use and Temporary Investments	$ 24,339,339	$ 22,407,515

NOTE 3 ASSETS LIMITED AS TO USE AND INVESTMENTS (CONTINUED)

Investment income and gains on investments, assets limited as to use, cash and cash equivalents, and other investments are comprised of the following for the years ended April 30:

	2025	2024
Interest and Dividend Income	$ 731,111	$ 371,193
Change in Unrealized Position on Investments	1,453,099	2,248,746
Total Investment Income	$ 2,184,210	$ 2,619,939

NOTE 4 PROPERTY AND EQUIPMENT

A summary of property and equipment at April 30 is as follows:

	2025	2024
Land and Improvements	$ 2,437,570	$ 2,943,968
Buildings and Improvements	21,468,395	22,243,463
Movable Equipment	26,233,944	25,933,921
Construction and Equipment Acquisition in Progress	1,860,215	381,764
Total, at Cost	52,000,124	51,503,116
Less: Accumulated Depreciation	34,148,145	32,882,725
Total Property and Equipment	$ 17,851,979	$ 18,620,391

Depreciation expense for the years ended April 30, 2025 and 2024, amounted to $4,440,963 and $4,256,634, respectively.

Construction in progress as of April 30, 2025, includes costs of various capital upgrades ongoing and will be completed during the year ending April 30, 2026.

NOTE 5 BONDS PAYABLE

Bonds payable consist of the following at April 30:

Description	2025	2024
City of Rochelle, Ogle County, Illinois Hospital Facility Revenue Bonds, Series 2009, which bear interest at 3.25%, principal due in varying annual installments of $285,000 to $286,000 through, August 1, 2029.	$ -	$ 1,713,000
Ogle County, Hospital Facility Revenue Bonds, Series 2015, which bear interest at 2.6%, principal due in annual installments of $239,036 through August 1, 2035.	2,629,401	2,868,436
Total	2,629,401	4,581,436
Less: Unamortized Debt Issuance Costs	(37,237)	(112,386)
Less: Current Portion	(239,036)	(525,036)
Long-Term Portion	$ 2,353,128	$ 3,944,014

Series 2009 Bonds

During fiscal year 2010, the City of Rochelle, Ogle County, Illinois, issued $7,000,000 of City of Rochelle Hospital Facility Revenue Bonds, Series 2009. The Series 2009 Revenue Bonds were issued under an Indenture of Trust with Castle Bank, N.A. During fiscal year 2025, the Hospital paid off the remaining balance of the bonds outstanding.

Series 2015 Bonds

In conjunction with the medical office building project, on August 18, 2015 the Hospital entered into a loan agreement with Ogle County Illinois as the conduit issuer of Hospital Facility Revenue Bonds series 2015. The bonds allowed the Hospital draw down proceeds as needed, but not to exceed $5,970,045. During fiscal year 2016, the Hospital borrowed $3,969,054. On June 1, 2016, the Hospital borrowed an additional $811,672 to cover the final cost of the project. On June 20, 2016, the Hospital refinanced the bonds. The bonds bear interest at 2.6% for the first five years and then resetting each subsequent five year period. The interest rate for the subsequent periods will be set at the lowest rate of interest that would enable the bonds to be sold at part, plus accrued interest, in no event to exceed the maximum rate of 12.0%. Quarterly interest payments are required each November, February, May, and August and annual principal payments are required on August 1 through maturity on August 1, 2035. The bonds are collateralized by substantially all assets and require maintenance of certain financial covenants for which management is not aware of any noncompliance at April 30, 2025.

NOTE 5 BONDS PAYABLE (CONTINUED)

Debt Issuance Costs

Costs totaling $326,067 associated with the issuance of the above noted bonds and their subsequent refinancing have been capitalized and are being amortized over the term of the related bonds based upon the straight-line method, which approximates the effective interest rate method. Issuance costs are $37,237 and $112,385, net of accumulated amortization, on the statements of financial position at April 30, 2025 and 2024, respectively, as a reduction of the bonds payable. Amortization for the years ended April 30, 2025 and 2024, was approximately $75,000 and $17,000, respectively.

Future Maturities

Scheduled maturity requirements on the long-term debt are as follows:

Year	Amount
2026	$ 239,036
2027	239,036
2028	239,036
2029	239,036
2030	239,036
Thereafter	1,434,221
Total	$ 2,629,401

NOTE 6 LONG-TERM LEASE OBLIGATIONS

The Hospital leases office space and equipment for various terms under long-term, noncancelable lease agreements. The leases expire at various dates through 2028 and provide for various renewal options. In the normal course of business, it is expected that these leases will be renewed or replaced by similar leases.

The following table provides quantitative information concerning the Hospital's leases for the year ended April 30:

Lease Costs:	2025	2024
Finance Lease Costs:		
Amortization of Right-of-Use Assets	$ 164,693	$ 143,493
Interest on Lease Liabilities	13,445	17,339
Operating Lease Costs	80,739	89,888
Total	$ 258,877	$ 250,720

NOTE 6 LONG-TERM LEASE OBLIGATIONS (CONTINUED)

Other Information:				
Cash Paid for Amounts Included in the Measurement of Lease Liabilities:				
Operating Cash Flows from Financing Leases	$	13,445	$	17,339
Operating Cash Flows from Operating Leases	$	79,447	$	86,644
Financing Cash Flows from Financing Leases	$	167,513	$	141,241
Right-of-Use Assets Obtained in Exchange for New Financing Lease Liabilities	$	87,443	$	-
Right-of-Use Assets Obtained in Exchange for New Operating Lease Liabilities	$	-	$	-
Weighted-Average Years Remaining Lease Term - Financing Leases		1.4 Years		2.3 Years
Weighted-Average Years Remaining Lease Term - Operating Leases		2.5 Years		3.3 Years
Weighted-Average Discount Rate - Financing Leases		4.01%		4.01%
Weighted-Average Discount Rate - Operating Leases		4.01%		4.01%

A maturity analysis of annual undiscounted cash flows for lease liabilities as of April 30, 2025, is as follows:

Year Ending December 31,	Financing Leases	Operating Leases
2026	$ 198,441	$ 72,883
2027	86,335	66,219
2028	-	45,020
Undiscounted Cash Flows	284,776	184,122
(Less) Imputed Interest	(8,485)	(9,238)
Total Present Value	$ 276,291	$ 174,884

NOTE 7 PATIENT SERVICE REVENUE

Patient service revenue is reported at the amount that reflects the consideration to which the Hospital expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Hospital bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

NOTE 7 PATIENT SERVICE REVENUE (CONTINUED)

Performance obligations are determined based on the nature of the services provided. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected or actual charges. The Hospital believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services or patients receiving services in outpatient clinics or in their homes (home care). The Hospital measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided and the Hospital does not believe it is required to provide additional goods or services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Hospital has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Hospital uses a portfolio approach to account for categories of patient contracts as a collective group, rather than recognizing revenue on an individual contract basis. The portfolios consist of major payor classes for inpatient revenue and outpatient revenue. Based on the historical collection trends and other analysis, The Hospital believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

The Hospital determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Hospital's policy, and/or implicit price concessions provided to uninsured patients. Estimated contractual adjustments and discounts are based on contractual agreements, its discount policy (or policies), and historical experience. Estimated implicit price concessions are based on its historical collection experience with this class of patients.

NOTE 7 PATIENT SERVICE REVENUE (CONTINUED)

The opening and closing contract balances were as follows:

	Patient Accounts Receivable
Balance as of May 1, 2023	$ 5,734,538
Balance as of April 30, 2024	6,058,277
Balance as of April 30, 2025	6,158,795

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between Hospital's billings at list price and the amounts reimbursed by Medicare, Medicaid, Blue Cross, and certain other third-party payors; any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. Contractual adjustments under third-party reimbursement programs are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined. A summary of the basis of reimbursement with major third-party payors follows:

Medicare

During the year ended April 30, 2002, the Hospital was designated as a critical access hospital. This designation provides for inpatient, outpatient, and swing bed services to be reimbursed on a cost basis methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization. The Hospital's Medicare cost reports have been finalized by the Medicare fiscal intermediary through April 30, 2023. Changes as a result of the Centers for Medicare and Medicaid Services implementation of the provision of the future Medicare legislation may have an adverse effect on the Hospital's net patient service revenue.

Medicaid

Inpatient and substantially all outpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates. In addition, the Hospital qualifies for additional payments under the state of Illinois Medicaid hospital assessment program. The Hospital pays certain annual assessments (provider tax) to the plan which generate additional funding. The Federal Centers for Medicare and Medicaid Services (CMS) approved state of Illinois (State) legislation for a Medicaid Hospital Assessment Program (Program). Under the Program, the Hospital receives additional Medicaid reimbursement from the State.

NOTE 7 PATIENT SERVICE REVENUE (CONTINUED)

Medicaid (Continued)

Under the assessment plan the Hospital received approximately $2.3M and $3.1M in payments and paid assessments of approximately $998,000 and $933,000 for the years ended April 30, 2025 and 2024, respectively. This additional reimbursement represented approximately 4% of the Hospital's net patient revenue for the years ended April 30, 2025 and 2024, respectively. The programs are subject to future modification through legislative action, specifically related to Medicaid reform initiatives.

Blue Cross

Services rendered to Blue Cross subscribers are reimbursed under the terms of a contract based on a set percentage of charges methodology. Revenue from Blue Cross programs accounted for approximately 19% of the Hospital's gross patient service revenue for the years ended April 30, 2025 and 2024.

Other

The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Uninsured

For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, an increased portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided.

Revenue from the Medicare and Medicaid programs accounted for approximately 51% and 15%, respectively, of the Hospital's gross patient service revenue for the year ended April 30, 2025, and 52% and 15%, respectively for the year ended April 30, 2024. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

There can be no assurance that regulatory authorities will not challenge the Hospital's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Hospital. In addition, the contracts the Hospital has with commercial payors also provide for retroactive audit and review of claims.

NOTE 7 PATIENT SERVICE REVENUE (CONTINUED)

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved.

Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Hospital also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Hospital estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue recognized due to the changes in its estimates of implicit price concessions, discounts, and contractual adjustments were not considered material for the years ended April 30, 2025 and 2024.

The Hospital provides care to patients regardless of their ability to pay. Therefore, the Hospital has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balance (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount the Hospital expects to collect based on its collection history with those patients. Patients who meet the Hospital's criteria for charity care are provided care without charge. Such amounts determined to qualify as charity care are not reported as revenue.

The Hospital has determined the nature, amount, timing and uncertainty of revenue and cash flows are affected by the following factors:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement/payment methodologies
- Length of patient's service/episode of care
- Geography of the service location
- Method of reimbursement (fee for service or capitation)
- The Hospital's line of business that provided the service (for example, hospital inpatient, hospital outpatient, clinic, etc.)

NOTE 7 PATIENT SERVICE REVENUE (CONTINUED)

For the years ended April 30, 2025 and 2024, all of the patient service revenue recognized by the Hospital was from goods and services that transfer to the customer over time.

NOTE 8 PENSION PLANS

401(k) Defined Contribution Plan

The Hospital has a 401(k) defined contribution plan that covers substantially all full-time employees. Eligible participants may contribute up to the maximum dollar amount and percentage determined by the federal government each year. Effective January 1, 2025 the Hospital matches 100% of the first 5% of compensation deposited as elective contributions. The amount of the discretionary employer contribution is set by the Hospital each year. The amount of the discretionary contribution for eligible participants is based on the relationship of their paid hours to total paid hours for all participants. The Hospital's expense under this plan was $625,594 and $449,757 for the year ended April 30, 2025 and 2024, respectively.

Deferred Compensation

The Hospital has a supplemental compensation agreement. The plan is administered on the basis of a plan year which begins on May 1 and ends on April 30. The purpose of the plan is to supplement the benefits provided to certain eligible employees. As of April 30, 2025 and 2024, the Hospital has reflected deferred compensation investments of $248,504 and $151,701, respectively. As of April 30, 2025 and 2024, the Hospital has reflected liabilities, which are classified as deferred compensation payable of $241,466 and $145,189, respectively.

NOTE 9 SELF-INSURANCE

Effective January 1, 2023, the Hospital transitioned to a fully insured health plan for employee health insurance through an independent insurer. As a result employee claims are now fully covered by the insurer after copays, deductibles, and coinsurance have been met, which the Hospital is partially funding on behalf of its employees.

The Hospital has recorded a liability based on its estimate of unpaid amount of incurred but not reported copays, deductibles, and coinsurance. The amount of liability recorded was $34,775 and $40,063 for April 30, 2025 and 2024, respectively. Such amounts are included in accrued expenses in the accompanying consolidated financial statements.

NOTE 10 CHARITY CARE

The Hospital maintains records to identify and monitor the level of charity care it provides. The Hospital provides charity care to patients whose income level is below 200% of the federal poverty level. The Hospital uses cost as the measurement basis for charity care disclosure purposes with the cost being identified as the direct and indirect costs of providing the charity care. Charity care includes the amount of costs forgone for services and supplies furnished under its charity care policy and was approximately $571,000 and $515,000 for the years ended April 30, 2025 and 2024, respectively. Charity care cost was determined on the application of the associated cost-to-charge ratio from the Medicare cost reports.

NOTE 11 CONCENTRATIONS OF CREDIT RISK

The Hospital is located in Rochelle, Illinois. The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows:

	2025	2024
Medicare	36 %	43 %
Medicaid	10	10
Commercial Insurance	26	27
Patients and Other Third-Party Payors	28	20
Total	100 %	100 %

NOTE 12 MEDICAL MALPRACTICE CLAIMS

The Hospital purchases professional and general liability insurance to cover medical malpractice claims. The policy is a claims made policy that has a retroactive date of January 1, 1976. In addition to the aforementioned policy, the Hospital has umbrella insurance coverage. There are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted arising from services provided to patients. The claims appear to be covered claims, and are in various stages of the discovery process and investigation.

Claims-made excess liability coverage is currently arranged through September 14, 2025. Coverage for claims made subsequent to September 14, 2025, is dependent upon the Hospital's ability to obtain claims-made insurance in the future. The Hospital uses an actuary to calculate an estimated liability for unpaid losses and incurred but not reported (IBNR) claims at year-end. This accrual is included in accrued expenses on the consolidated statements of financial position. A 3% discount rate was used for the fiscal years ending April 30, 2025 and 2024. The gross unpaid liability amount covering its hospital professional liability claims was approximately $778,000 at April 30, 2025 and 2024, respectively. A receivable amount of approximately $510,000 was also recorded to reflect the insurance transactions at April 30, 2025 and 2024, respectively.

NOTE 13 FUNCTIONAL EXPENSES

The Hospital provides general health care services to residents within the geographic location. Expenses related to providing these services as of April 30 are as follows:

	2025			
	Health Care Services		Support Services	
	Hospital Based Patient Services	Clinic Based Services	Administration	Total
Salaries and Benefits	$ 17,477,182	$ 5,841,345	$ 5,223,743	$ 28,542,270
Purchased Services	7,318,796	413,308	2,523,444	10,255,548
Supplies Expense	6,739,447	197,506	-	6,936,953
Depreciation and Amortization	3,107,868	346,544	1,151,060	4,605,472
Interest Expense	151,713	16,857	18,730	187,300
Other	1,102,784	64,361	143,617	1,310,762
Total	$ 35,897,790	$ 6,879,921	$ 9,060,594	$ 51,838,305

	2024			
	Health Care Services		Support Services	
	Hospital Based Patient Services	Clinic Based Services	Administration	Total
Salaries and Benefits	$ 15,692,857	$ 5,212,076	$ 4,833,631	$ 25,738,564
Purchased Services	6,868,072	273,339	2,468,519	9,609,930
Supplies Expense	5,936,047	174,265	-	6,110,312
Depreciation and Amortization	2,971,465	330,163	1,100,542	4,402,170
Interest Expense	136,528	15,170	16,856	168,554
Other	1,062,186	61,827	132,824	1,256,837
Total	$ 32,667,155	$ 6,066,840	$ 8,552,372	$ 47,286,367

NOTE 14 FAIR VALUE OF FINANCIAL INSTRUMENTS

In determining fair value, the Hospital uses various valuation approaches within the GAAP fair value measurement framework. Fair value measurements are determined based on the assumptions that market participants would use in pricing an asset or liability.

GAAP establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. GAAP defines levels within the hierarchy based on the reliability of inputs as follows:

Level 1 – Valuations based on unadjusted quoted prices for identical assets or liabilities in active markets;

Level 2 – Valuations based on quoted prices for similar assets or liabilities or identical assets or liabilities in less active markets, such as dealer or broker markets; and

NOTE 14 FAIR VALUE OF FINANCIAL INSTRUMENTS (CONTINUED)

Level 3 – Valuations derived from valuation techniques in which one or more significant inputs or significant value drivers are unobservable, such as pricing models, discounted cash flow models, and similar techniques not based on market, exchange, dealer, or broker-traded transactions.

A description of the valuation methodologies used for instruments measured at fair value, as well as the general classification of such instruments pursuant to the valuation hierarchy, follows:

Investments

Equity securities listed on a national market or exchange are valued at the last sales price, or if there is no sale and the market is still considered active, the last transaction price before year-end. Such securities are classified within Level 1 of the valuation hierarchy.

The following tables summarize financial assets and financial liabilities measured at fair value as of April 30, 2025 and 2024, segregated by the level of the valuation inputs within the fair value hierarchy utilized to measure fair value:

	2025			
	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs	Total Fair Value
Investments:				
Mutual Funds	$ 24,006,779	$ -	$ -	$ 24,006,779
Deferred Compensation Investments:				
Mutual Funds	248,504	-	-	248,504
Total	$ 24,255,283	$ -	$ -	$ 24,255,283

	2024			
	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs	Total Fair Value
Investments:				
Mutual Funds	$21,877,786	$ -	$ -	$21,877,786
Deferred Compensation Investments:				
Mutual Funds	151,701	-	-	151,701
Total	$ 22,029,487	$ -	$ -	$ 22,029,487

The estimated fair values of financial instruments have been derived, in part, by management's assumptions, the estimated amount and timing of future cash flows, and estimated discount rates. Different assumptions could significantly affect these estimated fair values. Accordingly, the net realizable value could be materially different from the estimates presented below. In addition, the estimates are only indicative of the value of individual financial instruments and should not be considered an indication of the fair value of the Hospital.

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
APRIL 30, 2025
(SEE INDEPENDENT AUDITORS' REPORT)

	Rochelle Community Hospital Association	Rochelle Community Hospital Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 27,544,973	$ 206,902	$ -	$ 27,751,875
Assets Limited as to Use Under Bond Agreement, Held by Trustee	244,619	-	-	244,619
Temporary Investments	23,417,403	677,317	-	24,094,720
Patient Accounts Receivable	6,158,795	-	-	6,158,795
Estimated Receivables, Third-Party Payors	429,909	-	-	429,909
Inventories	394,350	-	-	394,350
Other Receivables	807,245	-	-	807,245
Prepaid Expenses and Other Assets	1,672,372	-	-	1,672,372
Due from Affiliate	18,263	-	(18,263)	-
Total Current Assets	60,687,929	884,219	(18,263)	61,553,885
OTHER ASSETS				
Deferred Compensation Investments	248,504	-	-	248,504
Property and Equipment, Net	17,842,527	9,452	-	17,851,979
Financing Right-of-Use Assets	261,165	-	-	261,165
Operating Right-of-Use Assets	169,112	-	-	169,112
Total Other Assets	18,521,308	9,452	-	18,530,760
Total Assets	$ 79,209,237	$ 893,671	$ (18,263)	$ 80,084,645
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts Payable	$ 1,167,559	$ -	$ -	$ 1,167,559
Accrued Expenses	3,904,856	-	-	3,904,856
Due to Affiliate	-	18,263	(18,263)	-
Current Portion of Financing Lease Obligations	190,850	-	-	190,850
Current Portion of Operating Lease Obligations	67,213	-	-	67,213
Current Portion of Bonds Payable	239,036	-	-	239,036
Total Current Liabilities	5,569,514	18,263	(18,263)	5,569,514
LONG-TERM LIABILITIES				
Deferred Compensation Payable	241,466	-	-	241,466
Financing Long-Term Lease Obligations, Net	85,441	-	-	85,441
Operating Long-Term Lease Obligations, Net	107,671	-	-	107,671
Bonds Payable, Less Current Maturities	2,353,128	-	-	2,353,128
Total Long-Term Liabilities	2,787,706	-	-	2,787,706
Total Liabilities	8,357,220	18,263	(18,263)	8,357,220
NET ASSETS				
Net Assets Without Donor Restrictions	70,852,017	875,408	-	71,727,425
Total Liabilities and Net Assets	$ 79,209,237	$ 893,671	$ (18,263)	$ 80,084,645

Attachment 34-A

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATING STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS
YEAR ENDED APRIL 30, 2025
(SEE INDEPENDENT AUDITORS' REPORT)

	Rochelle Community Hospital Association	Rochelle Community Hospital Foundation	Eliminations	Consolidated
NET ASSETS WITHOUT DONOR RESTRICTIONS				
Operating Revenue:				
Patient Service Revenue	$ 52,814,394	$ -	$ -	$ 52,814,394
Other Revenue	467,047	90,891	-	557,938
Total Operating Revenue	53,281,441	90,891	-	53,372,332
Operating Expenses:				
Salaries and Wages	23,345,811	25,919	-	23,371,730
Employee Benefits	5,170,540	-	-	5,170,540
Purchased Services	10,611,822	-	-	10,611,822
Supplies, Drugs, Food, and Other	7,198,573	102,419	-	7,300,992
Depreciation	4,604,247	1,225	-	4,605,472
Interest	187,300	-	-	187,300
Insurance	590,449	-	-	590,449
Total Operating Expenses	51,708,742	129,563	-	51,838,305
INCOME FROM OPERATIONS	1,572,699	(38,672)	-	1,534,027
OTHER INCOME (EXPENSES)				
Other Investment Income	682,511	34,626	-	717,137
Gain on Disposal of Assets	(4,197)	-	-	(4,197)
Income on Investments Limited as to Use	731,111	-	-	731,111
Unrealized Gain on Investments	1,429,425	23,674	-	1,453,099
Total Other Income	2,838,850	58,300	-	2,897,150
EXCESS OF REVENUES OVER EXPENSES	4,411,549	19,628	-	4,431,177
Net Assets - Beginning of Year	66,440,468	855,780	-	67,296,248
NET ASSETS - END OF YEAR	$ 70,852,017	$ 875,408	$ -	$ 71,727,425

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATING STATEMENT OF CASH FLOWS
YEAR ENDED APRIL 30, 2025
(SEE INDEPENDENT AUDITORS' REPORT)

	Rochelle Community Hospital Association	Rochelle Community Hospital Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Increase in Net Assets	$ 4,411,549	$ 19,628	$ -	$ 4,431,177
Adjustments to Reconcile Increase in Net Assets to Net Cash Provided by Operating Activities and Gains and Losses:				
Depreciation	4,605,472	-	-	4,605,472
Amortization of Debt Issuance Costs	75,248	-	-	75,248
Interest Earned on Temporary Investments and Assets Limited as to Use	(731,111)	-	-	(731,111)
Loss on Disposal of Assets	4,197	-	-	4,197
Unrealized Gain on Investments	(1,476,773)	23,674	-	(1,453,099)
Effects of Changes in Operating Assets and Liabilities:				
Patient Accounts Receivable	(100,518)	-	-	(100,518)
Other Current Assets	(209,109)	-	-	(209,109)
Accounts Payable, Accrued Expenses and Other Liabilities	963,215	-	-	963,215
Estimated Receivables and Liabilities, Third-Party Payors	(382,705)	-	-	(382,705)
Net Cash Provided by Operating Activities	7,159,465	43,302	-	7,202,767
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Property and Equipment	(3,676,863)	-	-	(3,676,863)
Decrease in Due from Affiliate	20,468	-	(20,468)	-
Purchases of Temporary Investments and Assets Limited as to Use	192,202	(199,259)	-	(7,057)
Net Cash Used by Investing Activities	(3,464,193)	(199,259)	(20,468)	(3,683,920)
CASH FLOWS FROM FINANCING ACTIVITIES				
Payments on Bonds Payable	(1,952,134)	-	-	(1,952,134)
Payments on Finance Lease Obligations	(166,737)			(166,737)
Decrease in Due to Affiliate	-	(20,468)	20,468	-
Net Cash Used by Financing Activities	(2,118,871)	(20,468)	20,468	(2,118,871)
NET INCREASE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	1,576,401	(176,425)	-	1,399,976
Cash, Cash Equivalents, and Restricted Cash - Beginning of Year	27,019,907	32,713	-	27,052,620
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - END OF YEAR	$ 28,596,308	$ (143,712)	$ -	$ 28,452,596

Attachment 34-A

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
APRIL 30, 2024
(SEE INDEPENDENT AUDITORS' REPORT)

	Rochelle Community Hospital Association	Rochelle Community Hospital Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 26,140,790	$ 382,101	$ -	$ 26,522,891
Assets Limited as to Use Under Bond Agreement, Held by Trustee	505,435	-	-	505,435
Temporary Investments	21,400,348	501,732	-	21,902,080
Patient Accounts Receivable	6,058,277	-	-	6,058,277
Inventories	415,892	-	-	415,892
Other Receivables	832,145	-	-	832,145
Prepaid Expenses and Other Assets	1,415,932	-	-	1,415,932
Due from Affiliate	38,731	-	(38,731)	-
Total Current Assets	56,807,550	883,833	(38,731)	57,652,652
OTHER ASSETS				
Deferred Compensation Investments	151,701	-	-	151,701
Property and Equipment, Net	18,609,713	10,678	-	18,620,391
Financing Right-of-Use Assets	338,116	-	-	338,116
Operating Right-of-Use Assets	250,225	-	-	250,225
Total Other Assets	19,349,755	10,678	-	19,360,433
Total Assets	$ 76,157,305	$ 894,511	$ (38,731)	$ 77,013,085
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts Payable	$ 637,265	$ -	$ -	$ 637,265
Accrued Expenses	3,471,935	-	-	3,471,935
Estimated Liabilities, Third-Party Payors	382,705	-	-	382,705
Due to Affiliate	-	38,731	(38,731)	-
Current Portion of Financing Lease Obligations	143,312			143,312
Current Portion of Operating Lease Obligations	80,224			80,224
Current Portion of Bonds Payable	525,036	-	-	525,036
Total Current Liabilities	5,240,477	38,731	(38,731)	5,240,477
LONG-TERM LIABILITIES				
Deferred Compensation Payable	145,189	-	-	145,189
Financing Long-Term Lease Obligations, Net	212,273	-	-	212,273
Operating Long-Term Lease Obligations, Net	174,884	-	-	174,884
Bonds Payable, Less Current Maturities	3,944,014	-	-	3,944,014
Total Long-Term Liabilities	4,476,360	-	-	4,476,360
Total Liabilities	9,716,837	38,731	(38,731)	9,716,837
NET ASSETS				
Net Assets Without Donor Restrictions	66,440,468	855,780	-	67,296,248
Total Liabilities and Net Assets	$ 76,157,305	$ 894,511	$ (38,731)	$ 77,013,085

Attachment 34-A

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATING STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS
YEAR ENDED APRIL 30, 2024
(SEE INDEPENDENT AUDITORS' REPORT)

	Rochelle Community Hospital Association	Rochelle Community Hospital Foundation	Eliminations	Consolidated
NET ASSETS WITHOUT DONOR RESTRICTIONS				
Operating Revenue:				
Patient Service Revenue	$ 49,944,866	$ -	$ -	$ 49,944,866
Other Revenue	328,641	69,960	-	398,601
Total Operating Revenue	50,273,507	69,960	-	50,343,467
Operating Expenses:				
Salaries and Wages	21,413,178	23,189	-	21,436,367
Employee Benefits	4,302,197	-	-	4,302,197
Purchased Services	9,919,196	-	-	9,919,196
Supplies, Drugs, Food, and Other	6,443,950	43,825	-	6,487,775
Depreciation	4,402,170	408	-	4,402,578
Interest	168,554	-	-	168,554
Insurance	569,700	-	-	569,700
Total Operating Expenses	47,218,945	67,422	-	47,286,367
INCOME FROM OPERATIONS	3,054,562	2,538	-	3,057,100
OTHER INCOME (EXPENSES)				
Other Investment Income	472,947	17,973	-	490,920
Loss on Disposal of Assets	91,475	-	-	91,475
Income on Investments Limited as to Use	371,193	-	-	371,193
Unrealized Gain (Loss) on Investments	2,209,197	39,549	-	2,248,746
Total Other Income	3,144,812	57,522	-	3,202,334
EXCESS OF REVENUES OVER EXPENSES	6,199,374	60,060	-	6,259,434
Net Assets - Beginning of Year	60,241,094	795,720	-	61,036,814
NET ASSETS - END OF YEAR	$ 66,440,468	$ 855,780	$ -	$ 67,296,248

Attachment 34-A

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES
CONSOLIDATING STATEMENT OF CASH FLOWS
YEAR ENDED APRIL 30, 2024
(SEE INDEPENDENT AUDITORS' REPORT)

	Rochelle Community Hospital Association	Rochelle Community Hospital Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Increase in Net Assets	$ 6,199,374	$ 60,060	$ -	$ 6,259,434
Adjustments to Reconcile Increase in Net Assets to Net Cash Provided by Operating Activities and Gains and Losses:				
Depreciation	4,402,578	-	-	4,402,578
Amortization of Debt Issuance Costs	17,100	-	-	17,100
Interest Earned on Temporary Investments and Assets Limited as to Use	(371,193)	-	-	(371,193)
Loss on Disposal of Assets	(91,475)	-	-	(91,475)
Unrealized Gain on Investments	(2,288,295)	39,549	-	(2,248,746)
Effects of Changes in Operating Assets and Liabilities:				
Patient Accounts Receivable	(346,792)	-	-	(346,792)
Other Current Assets	(196,883)	-	-	(196,883)
Accounts Payable, Accrued Expenses and Other Liabilities	(115,499)	-	-	(115,499)
Estimated Receivables and Liabilities, Third-Party Payors	282,622	-	-	282,622
Net Cash Provided by Operating Activities	7,491,537	99,609	-	7,591,146
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Property and Equipment	(2,441,827)	-	-	(2,441,827)
Cash Received for Sale of Land	(20,487)	-	20,487	-
Decrease in Due from Affiliate	-	-	-	-
Purchases of Temporary Investments and Assets Limited as to Use	234,773	(87,383)	-	147,390
Net Cash Used by Investing Activities	(2,227,541)	(87,383)	20,487	(2,294,437)
CASH FLOWS FROM FINANCING ACTIVITIES				
Payments on Bonds Payable	(525,037)	-	-	(525,037)
Payments on Finance Lease Obligations	(141,569)			(141,569)
Decrease in Due to Affiliate	-	20,487	(20,487)	-
Net Cash Used by Financing Activities	(666,606)	20,487	(20,487)	(666,606)
NET INCREASE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	4,597,390	32,713	-	4,630,103
Cash, Cash Equivalents and Restricted Cash - Beginning of Year	22,307,347	115,170	-	22,422,517
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - END OF YEAR	$ 26,904,737	$ 147,883	$ -	$ 27,052,620

Attachment 34-A

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION
SCHEDULE OF COMMUNITY BENEFITS (UNAUDITED)
YEARS ENDED APRIL 30, 2025 AND 2024
(SEE INDEPENDENT AUDITORS' REPORT)

COMMUNITY COMMITMENT

Rochelle Community Hospital Association (the Hospital) is a nonprofit community owned hospital. In line with its mission and commitment to the community, the Hospital provides services to patients without regard to their ability to pay for those services. The Hospital has a Charity Care/Financial Assistance Program (the Program) for both the uninsured and the underinsured. Under the Program, patients are offered discounts of up to 100% of charges on a sliding scale, which is based both on the patient's income as a percentage of the federal poverty level guidelines, and the charges for services rendered. The Hospital receives no payment or a payment that is less than the full cost of providing the services for the patients under the Program. The amount of charges determined to be charity are not recorded as net patient service revenues.

In some instances, the Hospital will not receive payment for the services provided and has not received the necessary information from the patient in order to determine the patient's charitable assistance status. These charges are the basis for estimating the amount of patient revenue the Hospital will not collect and therefore report as bad debt expense.

The Hospital maintains records to identify and monitor the level of charity care it provides.

The Hospital's estimated total cost of uncompensated care relating to these services and other services are as follows for the years ended April 30:

	2025	2024
Medicaid Shortfalls at Cost	$ 3,134,129	$ 3,674,359
Less: Hospital Medicaid Assessment Program Payments, Net of Taxes Assessed	1,304,419	2,215,173
Uncompensated Costs of Public Aid Programs, Net	1,829,710	1,459,186
Charity Care, at Cost	571,330	515,598
Uncollectible Accounts, at Cost	1,099,377	962,324
Total Cost of Uncompensated Care	$ 3,500,417	$ 2,937,108

The cost of uncompensated care is estimated using the Hospital's overall cost to charge ratios. The uncompensated care cost of state Medicaid and other public aid programs is determined by computing the cost of providing that care less amounts paid by the programs.

Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported in net patient service revenue. Charges excluded from revenue under the Hospital's charity care program were approximately $1,512,000 and $1,415,000 at April 30, 2025 and 2024, respectively.

DARIN LAHOOD
18TH DISTRICT, ILLINOIS
LaHood.house.gov

COMMITTEE ON
WAYS AND MEANS

HOUSE PERMANENT SELECT
COMMITTEE ON INTELLIGENCE

SELECT COMMITTEE ON CHINA

Congress of the United States
House of Representatives

503 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-6201
FAX: (202) 225-9249

March 27, 2026

The Honorable Tom Cole
Chairman
House Committee on Appropriations
H-307 The Capitol
Washington, D.C. 20515

The Honorable Rosa DeLauro
Ranking Member
House Committee on Appropriations
1036 Longworth HOB
Washington, D.C. 20515

Dear Chairman Cole and Ranking Member DeLauro,

I am requesting funding for the Campus Redevelopment project in Fiscal Year 2027. The entity to receive funding for this project is Rochelle Community Hospital, located at 900 N 2nd St, Rochelle, IL 61068. The funding would be used for the construction and modernization of emergency, radiology, laboratory, and urgent care facilities.

The project is an appropriate use of taxpayer funds because Rochelle Community Hospital is a 25-bed independent critical access hospital whose oldest infrastructure dates to 1944, with 59 percent of mechanicals in the oldest portions of the building determined to be end-of-life. The six-bed Emergency Department treats between 8,000 and 9,000 patients annually and regularly exceeds capacity, the Laboratory processes over 87,000 specimens per year in less than 2,000 square feet with inadequate climate controls, and the facility's Convenient Care clinic is one of the only urgent care options within a ten-mile radius. The proposed construction will replace the failing 1944 structure with a purpose-built facility that expands emergency capacity, modernizes critical building systems, and ensures continued access to quality healthcare for a rural community with limited alternatives.

The project has a federal nexus because the funding provided is for purposes authorized under the Public Health Service Act.

I certify that I have no financial interest in this project, and neither does anyone in my immediate family.

Sincerely,

Darin LaHood
Member of Congress

NORMAL DISTRICT OFFICE
108 EAST BEAUFORT STREET
NORMAL, IL 61761
(309) 445-8080

PEORIA DISTRICT OFFICE
100 NE MONROE STREET, ROOM 100
PEORIA, IL 61602
(309) 671-7027
FAX: (309) 671-7309

ROCKFORD DISTRICT OFFICE
527 COLMAN CENTER DRIVE
ROCKFORD, IL 61108
(779) 238-4785

Attachment 34-B

Attachment 35 - Financial Viability

The Applicant has not sought bond financing in recent years as a result of its strong cash position and overall financial stability. The Applicant also recently paid off all outstanding bonded indebtedness, consisting of two prior bond issuances that were paid in full on September 30, 2024, and October 1, 2025, respectively, demonstrating the Applicant's strong financial position and conservative approach to debt. See audited financial statements included in Attachment 34.

As noted in Attachment 34, although the Applicant expects to receive supplemental funding through gifts and grants, offsetting a portion of the total project cost, the project is not dependent on such funding. The Applicant has the financial capacity to proceed with and complete the project using internal cash resources alone. As a result, pursuant to 77 Ill. Admin. Code § 1120.130(a)(1), the Applicant is not required to submit financial viability ratios because all project capital expenditures will be completely funded through internal resources.

Attachment 36 – Financial Viability Ratios

Not applicable. See Attachments 34 and 35.

Attachment 37 - Economic Feasibility

A. Reasonableness of Financing Arrangements

A letter attesting that the total estimated project costs will be funded in total with cash and equivalents is attached.

B. Conditions of Debt Financing

Not applicable as the project does not involve debt financing.

C. Reasonableness of Project and Related Costs

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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Clinical	New	Mod.	New**	Circ.%	Mod.**	Circ.%			
Emergency Department	$714.00		7,184	34%	-	-	$5,130,094	-	$5,130,094
General Radiology	$818.00		6,851	25%	-	-	$5,604,118	-	$5,604,118
Lab	$436.00		3,485	24%	-	-	$1,520,331	--	$1,520,331
Convenient Care	$434.00		2,120	25%	-	-	$920,089	-	$920,089
Total Clinical	**$671.00**		**19,640**	**28%**		-	**$13,174,633**		**$13,174,633**
Non-Clinical									
Administrative		$650.00			9,843	50.1%		$5,344,754	$5,344,754
Patient Reg/Circ/Staff/Loading Dock	$1,137	$650.00	13,568	29%	1,325	-	$15,422,395	$719,529	$14,788,189
Material Management		$650.00		-	2,802	-		$1,520,796	$1,520,796
Total Non-Clinical	**$1,137**	**$650.00**	**13,568**	**29%**	**13,970**	**33%**	**$15,422,395**	**$7,585,080**	**$23,007,475**
TOTALS			**33,208**		**13,970**		**$28,597,028**	**$7,585,080**	**$36,182,108**

* Include the percentage (%) of space for circulation
**Includes circulation and ancillary support space

The proposed project meets all state standards, other than Site Survey, Soil Investigation, and Site Preparation costs. As noted below, however, the costs are reasonable and justified consistent with Section 1120.140(c)(2).

1. Preplanning. Preplanning costs assigned to clinical uses are $215,879 or 1.34% of the sum of new construction ($13,174,633), contingency costs ($2,130,469), and equipment costs ($834,000) assigned to clinical uses (total: $16,139,102). This is below the state standard of 1.8%. Therefore, preplanning costs meet the state standard.

2. Site Survey, Soil Investigation, and Site Preparation. The total costs for site survey, soil investigation, and site preparation assigned to clinical uses are $1,385,825 or 9.05% of the sum of new construction ($13,174,633) and contingency costs ($2,130,469) assigned to clinical uses (total: $15,305,102), which is above the state standard of 5%.

   The costs exceed the state standard of 5% due to site constraints and complexities, including major utility relocations required to construct the new addition, costs associated with the demolition, and costs related to limestone excavation at the basement level, which is approximately 2-4 feet below grade. These costs are consistent with other projects that have experienced similar constraints and complexities and, therefore, reasonable, consistent with Section 1120.140(c)(2).

3. New Construction. New construction costs assigned to clinical uses are $13,174,633 or $670.80 per GSF ($13,174,633 / 19,640). This amount is below the state standard of $722.87 per GSF.[8]

4. Modernization Contracts and Contingency. There are no modernization costs assigned to clinical uses.

5. Contingencies. Contingency costs assigned to clinical uses are $2,130,469, or 7.38% of new construction costs assigned to clinical uses ($13,174,633). This is below the state standard of 10% for new construction costs for projects in the schematics stage. Therefore, contingency costs meet the state standard.

6. Architectural and Engineering Fees. Architectural and engineering fees assigned to clinical uses are $1,138,776 or 6.05% of the sum of new construction costs ($13,174,633) and contingency costs ($2,130,469) assigned to clinical uses (total: $18,814,239). This is within the state standard range for new construction (5.64-8.48%). Therefore, the architectural and engineering fees meet the state standard.

There are no other applicable state standards related to the project costs assigned to clinical uses.

D. Projected Direct Annual Operating Costs

Below are the projected direct annual operating costs for the first two years following project completion.

	FY 2031	FY 2032

[8] Assumes 2028 as project mid-point.

Direct Operating Expenses	$40,430,596	$41,770,871
Total Adjusted Patient Days	20,693	21,339
Direct Operating Costs per Adjusted Patient Day	$1,954	$1,958

E. Total Effect of Project on Capital Costs

Below are the total projected annual capital costs for the first two years following project completion.

	FY 2031	FY 2032
Capital Costs (Est. Depreciation)	$1,734,983	$1,734,983
Total Adjusted Patient Days	20,693	21,339
Capital Costs per Adjusted Patient Day	$84	$81

Attachment 37

Rochelle
Community Hospital

May 4, 2026

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

Re: Rochelle Community Hospital Project
Reasonableness of Financing Arrangements

Dear Mr. Kniery:

On behalf of Rochelle Community Hospital, I hereby attest that the total estimated project costs and related costs will be funded in total with cash and equivalents, including, without limitation, unrestricted funds, pledges, and grants.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Lori Gutierrez
Chief Financial Officer
Rochelle Community Hospital

Subscribed and sworn to before me
This 4 day of May, 2026

Kimberly S. Louis
Notary Public

"OFFICIAL SEAL"
Kimberly S. Louis
Notary Public, State of Illinois
My Commission Expires 06/24/2027

Attachment 38 - Safety Net Impact Statement

This attachment is not applicable as the proposed project is classified as "non-substantive."

Attachment 39 – Charity Care

The table below lists the amount of charity care provided by the Applicant in the last three years.

CHARITY CARE			
	2023	**2024**	**2025**
Net Patient Revenue	**50,395,943**	**49,944,866**	**52,814,394**
Amount of Charity Care (charges)	1,154,298	1,414,926	1,511,555
Cost of Charity Care	444,369	517,404	568,341

Attachment 39