

May 8, 2026

WRITER'S DIRECT NUMBER: 312-705-6012  
EMAIL: [Rebecca.Lindstrom@icemiller.com](mailto:Rebecca.Lindstrom@icemiller.com)**Via Federal Express and E-Mail ([DPH.HFSRB@illinois.gov](mailto:DPH.HFSRB@illinois.gov))**

Mr. John Kniery, Administrator  
Illinois Health Facilities and Services Review Board ("HFSRB")  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, IL 62761

*RE: Application for Permit – Rochelle Community Hospital Association  
Request for Expedited Review*

Dear Mr. Kniery:

On behalf of Rochelle Community Hospital Association ("RCH"), please find enclosed an original and 1 copy of an Application for Permit. A check in the amount of \$5,000 for the application processing fee is enclosed.

RCH respectfully requests expedited review and consideration of the project at the July 21, 2026 HFSRB meeting.

Thank you for your time and consideration of the request for expedited review and for your time evaluating the application. If you have any questions or require any additional information to complete your review, please do not hesitate to contact me.

Sincerely,

ICE MILLER LLP

*/s/Rebecca Lindstrom*

Rebecca Lindstrom

Enclosures – Certificate of Need Permit Application  
\$5,000 check for application processing fee

CHECK NO. 220801  
VENDOR 10371

DATE 04/30/26

| INVOICE<br>NUMBER | INVOICE<br>DATE | INVOICE DESCRIPTION            | NET AMOUNT<br>THIS CHECK |
|-------------------|-----------------|--------------------------------|--------------------------|
| 04302026          | 04/30/26        | CON Application Processing Fee | \$5,000.00               |
| TOTALS            |                 |                                | NET AMOUNT<br>\$5,000.00 |

Page 1 of 1

TO VERIFY AUTHENTICITY, SEE REVERSE SIDE FOR DESCRIPTION OF THE 11 SECURITY FEATURES

Rochelle Community Hospital Association  
900 North Second Street  
Rochelle, IL 61068

500  
711  
Central Bank Illinois

CHECK DATE  
04/30/26

CHECK NUMBER  
220801

PAY THIS AMOUNT

\*\*\*\*\$5,000.00

PAY EXACTLY Five Thousand Dollars And 00/100 Cents

PAY TO THE ORDER OF ILLINOIS DEPT. OF PUBLIC HEALTH  
PO BOX 4263  
SPRINGFIELD, IL 62708

*[Signature]*

⑈ 220801 ⑈ ⑆071105002⑆ 80188701⑈

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

### SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

**This Section must be completed for all projects.**

#### Facility/Project Identification

|                                               |                        |                            |
|-----------------------------------------------|------------------------|----------------------------|
| Facility Name: Rochelle Community Hospital    |                        |                            |
| Street Address: 900 N. 2 <sup>nd</sup> Street |                        |                            |
| City and Zip Code: Rochelle, 61068            |                        |                            |
| County: Ogle                                  | Health Service Area: 1 | Health Planning Area: B-04 |

#### Applicant(s) [Provide for each applicant (refer to 77 Ill. Adm. Code 1130.220)]

|                                                                |  |  |
|----------------------------------------------------------------|--|--|
| Exact Legal Name: Rochelle Community Hospital Association      |  |  |
| Street Address: 900 N. 2 <sup>nd</sup> Street                  |  |  |
| City and Zip Code: Rochelle, 61068                             |  |  |
| Name of Registered Agent: Lori Lynn Gutierrez                  |  |  |
| Registered Agent Street Address: 900 N. 2 <sup>nd</sup> Street |  |  |
| Registered Agent City and Zip Code: Rochelle, 61068            |  |  |
| Name of Chief Executive Officer: Karen Tracy, RN               |  |  |
| CEO Street Address: 900 N. 2 <sup>nd</sup> Street              |  |  |
| CEO City and Zip Code: Rochelle, 61068                         |  |  |
| CEO Telephone Number: 815.562.2480                             |  |  |

#### Type of Ownership of Applicants

|                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                               |                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| <input checked="checked" type="checkbox"/> Non-profit Corporation<br><input type="checkbox"/> For-profit Corporation<br><input type="checkbox"/> Limited Liability Company                                                                                                                                                                                                          | <input type="checkbox"/> Partnership<br><input type="checkbox"/> Governmental<br><input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Other |
| <ul style="list-style-type: none"> <li>○ Corporations and limited liability companies must provide an <b>certificate of good standing from the Illinois Secretary of State.</b></li> <li>○ Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.</li> </ul> |                                                                                                                               |                                |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                                                                                                                                                                |                                                                                                                               |                                |

#### Primary Contact [Person to receive ALL correspondence or inquiries]

|                                                                              |
|------------------------------------------------------------------------------|
| Name: Lori Lynn Gutierrez                                                    |
| Title: Chief Financial Officer, CPA                                          |
| Company Name: Rochelle Community Hospital                                    |
| Address: 900 N. 2 <sup>nd</sup> Street, Rochelle, IL 61068                   |
| Telephone Number: 815-561-3108                                               |
| E-mail Address: <a href="mailto:LGutierrez@rcha.net">LGutierrez@rcha.net</a> |
| Fax Number:                                                                  |

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

|                                                                                                      |
|------------------------------------------------------------------------------------------------------|
| Name: Rebecca M. Lindstrom                                                                           |
| Title: Attorney                                                                                      |
| Company Name: Ice Miller                                                                             |
| Address: 200 W. Madison Street, Ste. 3500, Chicago, IL 60606                                         |
| Telephone Number: 312-705-6012                                                                       |
| E-mail Address: <a href="mailto:rebecca.lindstrom@icemiller.com">rebecca.lindstrom@icemiller.com</a> |
| Fax Number:                                                                                          |

**Post Permit Contact**

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

|                                                                              |
|------------------------------------------------------------------------------|
| Name: Lori Lynn Gutierrez, CPA                                               |
| Title: Chief Financial Officer                                               |
| Company Name: Rochelle Community Hospital                                    |
| Address: 900 N. 2 <sup>nd</sup> Street, Rochelle, IL 61068                   |
| Telephone Number: 815-561-3108                                               |
| E-mail Address: <a href="mailto:LGutierrez@rcha.net">LGutierrez@rcha.net</a> |
| Fax Number:                                                                  |

**Site Ownership**

[Provide this information for each applicable site]

|                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Exact Legal Name of Site Owner: Rochelle Community Hospital Association                                                                                                                                                                                                                                        |
| Address of Site Owner: 900 N. 2 <sup>nd</sup> Street, Rochelle, IL 61068                                                                                                                                                                                                                                       |
| Street Address or Legal Description of the Site: 900 N. 2 <sup>nd</sup> Street, Rochelle, IL 61068, PIN: 24-24-251-001                                                                                                                                                                                         |
| <b>Proof of ownership or control of the site must be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.</b> |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                                                                                          |

**Operating Identity/Licensee**

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Exact Legal Name: Rochelle Community Hospital Association                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Address: 900 N. 2 <sup>nd</sup> Street, Rochelle, IL 61068                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> Non-profit Corporation<br/> <input type="checkbox"/> For-profit Corporation<br/> <input type="checkbox"/> Limited Liability Company         </div> <div> <input type="checkbox"/> Partnership<br/> <input type="checkbox"/> Governmental<br/> <input type="checkbox"/> Sole Proprietorship         </div> <div> <input type="checkbox"/> Other         </div> </div> <ul style="list-style-type: none"> <li>○ Corporations and limited liability companies must provide a Certificate of Good Standing from the Illinois Secretary of State.</li> <li>○ Partnerships must provide the name of the state in which organized and the <b>name and address of each partner specifying whether each is a general or limited partner.</b></li> <li>○ <b>Persons with 5% or greater interest in the licensee must be identified with the percentage of ownership.</b></li> </ul> |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

**Organizational Relationships**

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in 77 Ill. Adm. Code 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

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



**Flood Plain Requirements**

[Refer to application instructions.]

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

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

**Historic Resources Preservation Act Requirements**

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act. Information can be found at [Preserve History - Preservation](#)

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

**DESCRIPTION OF PROJECT****1. Project Classification**

[Check those applicable - refer to 77 Ill. Adm. Code 1110.20 and 77 Ill. Adm. Code 1120.20(b)]

Part 1110 Classification :

- ☐ Substantive
- ☒ Non-substantive

## 2. Narrative Description

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

Rochelle Community Hospital Association ("Rochelle Community Hospital" or "RCH" or "Applicant") is a 16-bed critical access hospital that provides inpatient, outpatient, and emergency care services. RCH is located in Rochelle, Illinois, a community of approximately 9,500 residents located 108 miles west of Chicago in Ogle County, which is designated as a rural area by the Federal Office of Rural Health Policy.

The proposed project is a much-needed, carefully planned modernization initiative designed to address functional limitations and infrastructure issues associated with a dated hospital campus and better align existing services with current standards of care and community needs. The project includes the relocation and expansion of the existing 6-station Emergency Department ("ED") into a 10-station ED that is appropriately sized to better accommodate current utilization, future demand, and behavioral health needs in the community. To support emergency services and maintain stroke readiness, the Radiology Department will be relocated adjacent to the ED, allowing for improved care coordination and replacement of an outdated nuclear medicine machine that could not otherwise be accommodated within the size constraints of the current department. The existing Convenient Care will also be relocated adjacent to the ED, enabling shared staffing for triage functions and improving access to walk-in care for non-emergent conditions. In addition, the Laboratory Department will be relocated and expanded to provide adequately sized clinical and support spaces that enhance workflow efficiency and support modern diagnostic capabilities. The project includes removal of an existing aging building (more than 80 years old) on the hospital campus to allow for construction of a new structure on the same site, which will house the relocated ED, Radiology Department, Convenient Care, and Laboratory Department. The project further reconfigures campus access to improve wayfinding and operational efficiency by establishing a clearly defined primary public entrance for hospital services and a separate access point dedicated to materials management and deliveries. The majority of the hospital's infrastructure systems are beyond their useful life and in need of major upgrades or replacement. The project will proactively address these conditions while ensuring compliance with current code requirements, accessibility standards, and applicable environmental regulations. Collectively, these improvements will modernize critical hospital infrastructure, enhance patient access and safety, and ensure the facility is positioned to meet current and future community needs.

The total project cost is \$48,579,513.

The project is classified as "non-substantive" under the regulations of the Illinois Health Facilities and Services Review Board ("HFSRB").

## Project Costs and Sources of Funds

Complete the following table listing all costs (refer to 77 Ill. Adm Code 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to 77 Ill. Adm. Code 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

| Project Costs and Sources of Funds                                                                                                                    |                   |                   |                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------|-------------------|
| USE OF FUNDS                                                                                                                                          | CLINICAL          | NONCLINICAL       | TOTAL             |
| Preplanning Costs                                                                                                                                     | 215,879           | 258,076           | 473,955           |
| Site Survey and Soil Investigation                                                                                                                    | 181,654           | 213,246           | 394,900           |
| Site Preparation                                                                                                                                      | 1,204,171         | 1,413,592         | 2,617,763         |
| Off Site Work                                                                                                                                         |                   | 56,733            | 56,733            |
| New Construction Contracts                                                                                                                            | 13,174,633        | 15,422,395        | 28,597,028        |
| Modernization Contracts                                                                                                                               |                   | 7,585,080         | 7,585,080         |
| Contingencies                                                                                                                                         | 2,130,469         | 2,750,985         | 4,881,454         |
| Architectural/Engineering Fees                                                                                                                        | 1,138,776         | 1,336,824         | 2,475,600         |
| Consulting and Other Fees                                                                                                                             | 94,300            | 110,700           | 205,000           |
| Movable or Other Equipment (not in construction contracts)                                                                                            | 832,000           | 90,000            | 922,000           |
| Bond Issuance Expense (project related)                                                                                                               |                   |                   | -                 |
| Net Interest Expense During Construction (project related)                                                                                            |                   |                   | -                 |
| Fair Market Value of Leased Space or Equipment                                                                                                        |                   |                   | -                 |
| Other Costs to Be Capitalized                                                                                                                         | 170,200           | 199,800           | 370,000           |
| Acquisition of Building or Other Property (excluding land)                                                                                            |                   |                   | -                 |
| <b>TOTAL USES OF FUNDS</b>                                                                                                                            | <b>19,142,082</b> | <b>29,437,431</b> | <b>48,579,513</b> |
| SOURCE OF FUNDS                                                                                                                                       | CLINICAL          | NONCLINICAL       | TOTAL             |
| Cash and Securities                                                                                                                                   | 19,142,082        | 29,437,431        | 48,579,513        |
| Pledges                                                                                                                                               |                   |                   |                   |
| Gifts and Bequests                                                                                                                                    |                   |                   |                   |
| Bond Issues (project related)                                                                                                                         |                   |                   |                   |
| Mortgages                                                                                                                                             |                   |                   |                   |
| Leases (fair market value)                                                                                                                            |                   |                   |                   |
| Governmental Appropriations                                                                                                                           |                   |                   |                   |
| Grants                                                                                                                                                |                   |                   |                   |
| Other Funds and Sources                                                                                                                               |                   |                   |                   |
| <b>TOTAL SOURCES OF FUNDS</b>                                                                                                                         | <b>19,142,082</b> | <b>29,437,431</b> | <b>48,579,513</b> |
| <b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b> |                   |                   |                   |

**Related Project Costs**

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Purchase Price: \$ _____</p> <p>Fair Market Value: \$ _____</p>                                                                                                                                                                                                                                                                                                                                  |
| <p>The project involves the establishment of a new facility or a new category of service<br/> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, provide the dollar amount of all <b>non-capitalized</b> operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in 77 Ill. Adm. Code 1100.</p> <p>Estimated start-up costs and operating deficit cost is \$ <u>N/A</u>.</p> |

**Project Status and Completion Schedules**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>For facilities in which prior permits have been issued, please provide the permit numbers.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>Indicate the stage of the project's architectural drawings:</p> <p style="text-align: center;"> <input type="checkbox"/> None or not applicable <span style="margin-left: 100px;"><input type="checkbox"/> Preliminary</span><br/> <input checked="" type="checkbox"/> Schematics <span style="margin-left: 100px;"><input type="checkbox"/> Final Working</span> </p>                                                                                                                                                                                                                           |
| <p>Project completion date (refer to 77 Ill. Adm Cod 1130.140): <u>April 30, 2030</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p>Indicate the following with respect to project expenditures or to financial commitments (refer to 77 Ill. Adm. Code 1130.140):</p> <p> <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.<br/> <input type="checkbox"/> Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies<br/> <input checked="" type="checkbox"/> Financial Commitment will occur after permit issuance.         </p> |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

**State Agency Submittals** [77 Ill. Adm. Code 1130.620(b)(3)(H), 77 Ill. Adm. Code 840.110(d), 77 Ill. Adm. Code 840.115(i), 77 Ill. Adm Code 840.210(a)]

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Are the following submittals up to date as applicable?</p> <p> <input checked="" type="checkbox"/> Cancer Registry<br/> <input checked="" type="checkbox"/> Adverse Pregnancy Outcomes Reporting System (APORS)<br/> <input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted<br/> <input type="checkbox"/> All reports regarding outstanding permits <b>Not applicable</b> </p> <p><b>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</b></p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## Cost Space Requirements

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

**Non-clinical Service Area:** means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; components in patient care unit used as educational space, consultation and touchdown rooms, and on-call; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Non-clinical service area does not include health and fitness centers, areas in a patient care unit, or areas that are required by Department licensing standards, including life safety code regulations, such as hallways and other interdependent components to a clinical area. [20 ILCS 3960/3]

| Dept. / Area                        | Cost***           | Gross Square Feet |               | Amount of Proposed Total Gross Square Feet That Is: |               |          |                |
|-------------------------------------|-------------------|-------------------|---------------|-----------------------------------------------------|---------------|----------|----------------|
|                                     |                   | Existing          | Proposed**    | New Const.**                                        | Modernized**  | As Is    | Vacated Space* |
| <b>CLINICAL</b>                     |                   |                   |               |                                                     |               |          |                |
| Emergency Department                | 7,088,111         | 4989              | 7184          | 7184                                                | -             | -        | 4989           |
| General Radiology                   | 6,756,363         | 5593              | 6851          | 6851                                                | -             | -        | 5593           |
| Lab                                 | 3,151,036         | 2678              | 3485          | 3485                                                | -             | -        | 2678           |
| Convenient Care                     | 2,146,572         | 1829              | 2120          | 2120                                                | -             | -        | 1829           |
| <b>Total Clinical</b>               | <b>19,142,082</b> | <b>15,089</b>     | <b>19,640</b> | <b>19,640</b>                                       | <b>-</b>      | <b>-</b> | <b>15,089</b>  |
| <b>NON-CLINICAL</b>                 |                   |                   |               |                                                     |               |          |                |
| Administrative                      | 10,629,755        | -                 | 9843          | -                                                   | 9843          | -        | -              |
| Patient Reg/Circ/Staff/Loading Dock | 16,120,609        | -                 | 14,893        | 13,568                                              | 1325          | -        | -              |
| Material Management                 | 2,687,067         | -                 | 2802          | -                                                   | 2802          | -        | -              |
| <b>Total Non-Clinical</b>           | <b>29,437,431</b> | <b>-</b>          | <b>27,538</b> | <b>13,568</b>                                       | <b>13,970</b> | <b>-</b> | <b>-</b>       |
| <b>TOTAL</b>                        | <b>48,579,513</b> |                   | <b>47,178</b> | <b>33,208</b>                                       | <b>13,970</b> | <b>-</b> | <b>15,089</b>  |

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

\*Vacated space will be used for administrative and storage space.

\*\*Includes circulation and ancillary support space

\*\*\*Includes other project costs assigned to clinical use or non-clinical use, as applicable, including contingency costs, architectural/engineering fees, etc.

## Facility Bed Capacity and Utilization

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

| <b>FACILITY NAME: Rochelle Community Hospital</b>            |                        |                   | <b>CITY: Rochelle</b> |                    |                      |
|--------------------------------------------------------------|------------------------|-------------------|-----------------------|--------------------|----------------------|
| <b>REPORTING PERIOD DATES: From: 1/1/2025 to: 12/31/2025</b> |                        |                   |                       |                    |                      |
| <b>Category of Service</b>                                   | <b>Authorized Beds</b> | <b>Admissions</b> | <b>Patient Days</b>   | <b>Bed Changes</b> | <b>Proposed Beds</b> |
| <b>Medical/Surgical</b>                                      | <b>12</b>              | <b>263</b>        | <b>751</b>            | N/A                | N/A                  |
| Obstetrics                                                   | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| Pediatrics                                                   | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| <b>Intensive Care</b>                                        | <b>4</b>               | <b>0</b>          | <b>0</b>              | N/A                | N/A                  |
| Comprehensive Physical Rehabilitation                        | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| Acute/Chronic Mental Illness                                 | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| Neonatal Intensive Care                                      | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| General Long-Term Care                                       | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| Specialized Long-Term Care                                   | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| Long Term Acute Care                                         | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| Other (identify)                                             | N/A                    | N/A               | N/A                   | N/A                | N/A                  |
| <b>TOTALS:</b>                                               | <b>16</b>              | <b>263</b>        | <b>751</b>            | N/A                | N/A                  |

## CERTIFICATION

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

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

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

Karen Tracy  
SIGNATURE

Karen Tracy  
PRINTED NAME

Chief Executive Officer  
PRINTED TITLE

Brent Ohlinger  
SIGNATURE

Brent Ohlinger  
PRINTED NAME

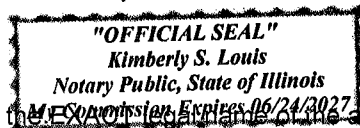
Chairman  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this 7 day of May, 2024

Kimberly S. Louis  
Signature of Notary

Seal



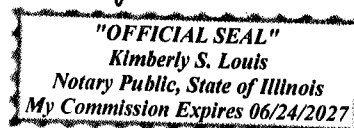
\*Insert the Notary Seal and Name of the applicant

Notarization:

Subscribed and sworn to before me  
this 7 day of May, 2024

Kimberly S. Louis  
Signature of Notary

Seal



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

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

#### 77 III. Adm. Code 1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

##### BACKGROUND OF APPLICANT

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

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



**Criterion 77 III. Adm. Code 1110.110(b) & (d)****PURPOSE OF PROJECT**

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

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

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

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

**ALTERNATIVES**

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost.
- B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes.
- C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
- D) Provide the reasons why the chosen alternative was selected.

- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality, and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

**SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE****Criterion 77 III. Adm. Code 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

**SIZE OF PROJECT:**

1. Document that the amount of physical space proposed for the project is necessary and not excessive. **This must be a narrative, and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in 77 III. Adm. Code 1110. Appendix B, justify the discrepancy by documenting one of the following:
  - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
  - c. The project involves the conversion of existing space that results in excess square footage.
  - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when 77 III. Adm. Code 1110. Appendix B standards were adopted.

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

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

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

**PROJECT SERVICES UTILIZATION:**

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

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 77 III. Adm. Code 1110. Appendix B. **A narrative of the rationale that supports the projections must be provided.**

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

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

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

**UNFINISHED OR SHELL SPACE: NOT APPLICABLE**

Provide the following information:

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

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

**ASSURANCES: NOT APPLICABLE**

Submit the following:

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

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

**SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA****M. Criterion 77 Ill. Adm. Code 1110.270 - Clinical Service Areas Other than Categories of Service**

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

| Service                                                          | # Existing Key Rooms | # Proposed Key Rooms |
|------------------------------------------------------------------|----------------------|----------------------|
| <input checked="" type="checkbox"/> Emergency Services           | 6 Stations           | 10 Stations          |
| <input checked="" type="checkbox"/> Diagnostic Radiology/Imaging | N/A                  | N/A                  |
| <input checked="" type="checkbox"/> Laboratory                   | N/A                  | N/A                  |

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

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

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

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

## VII. Criterion – 77 III. Adm. Code 1120.120 - AVAILABILITY OF FUNDS

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

|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>48,579,513</b></p> | <p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> <li>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</li> <li>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.</li> </ol> <p>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.</p> <p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.</p> <p>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:</p> <ol style="list-style-type: none"> <li>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.</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate.</li> <li>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.</li> <li>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.</li> </ol> |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                               |                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                               | 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.                                                                                                                                                                                                            |
| <b><u>48,579,513</u></b>                                                                                                      | <b>TOTAL FUNDS AVAILABLE</b>                                                                                                                                                                                                                                                                                                          |
| <b>APPEND DOCUMENTATION AS <u>ATTACHMENT 34</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b> |                                                                                                                                                                                                                                                                                                                                       |

**SECTION VIII. Criterion – 77 Ill. Adm. Code 1120.130 - FINANCIAL VIABILITY**

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

**Financial Viability Waiver**

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

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

See Section 77 Ill. Adm. Co 1120.130 Financial Waiver for information to be provided

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

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

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

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

**Variance**

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

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

**SECTION IX. 1120.140 - ECONOMIC FEASIBILITY**

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

**A. Reasonableness of Financing Arrangements**

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

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

**B. Conditions of Debt Financing**

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

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

**C. Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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



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

\* Include the percentage (%) of space for circulation

**D. Projected Operating Costs**

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

**E. Total Effect of the Project on Capital Costs**

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

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

**SECTION X. CHARITY CARE INFORMATION**

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

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

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

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

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

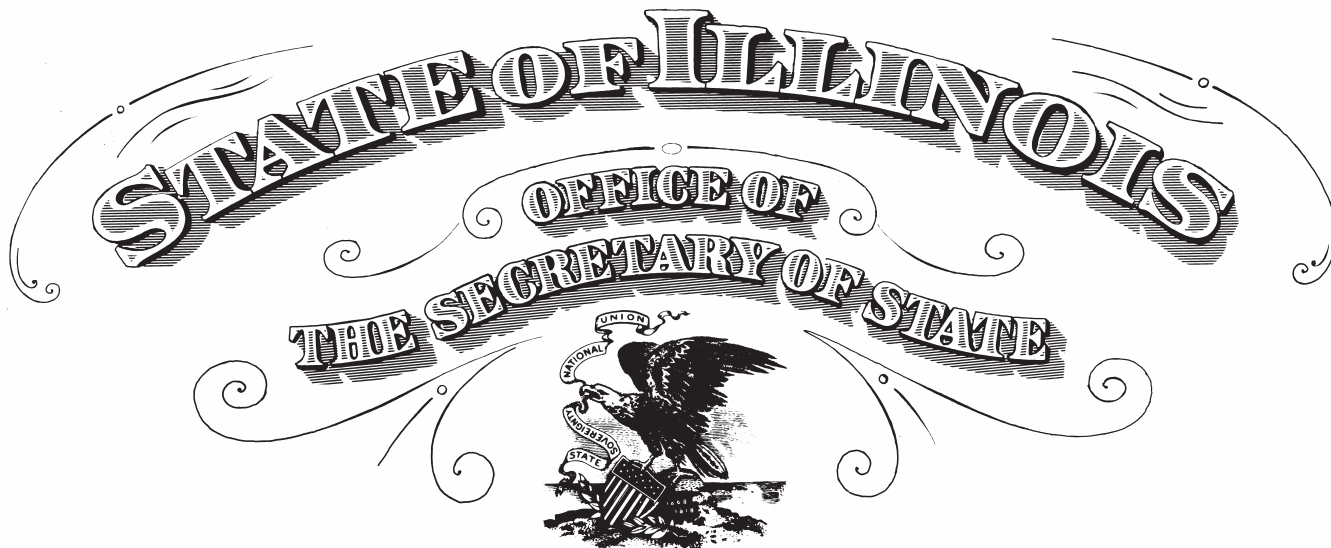
APPEND DOCUMENTATION AS **ATTACHMENT 39**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

| INDEX OF ATTACHMENTS |                                                                                                        |  |          |
|----------------------|--------------------------------------------------------------------------------------------------------|--|----------|
| ATTACHMENT NO.       |                                                                                                        |  | PAGES    |
| 1                    | Applicant Identification including Certificate of Good Standing                                        |  | 22-23    |
| 2                    | Site Ownership                                                                                         |  | 24-27    |
| 3                    | Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. |  | 28       |
| 4                    | Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.                  |  | 29-30    |
| 5                    | Flood Plain Requirements                                                                               |  | 31       |
| 6                    | Historic Preservation Act Requirements                                                                 |  | 32       |
| 7                    | Project and Sources of Funds Itemization                                                               |  | 33-34    |
| 8                    | Financial Commitment Document if required                                                              |  | 35       |
| 9                    | Cost Space Requirements                                                                                |  | 36       |
| 10                   | Discontinuation                                                                                        |  | N/A      |
| 11                   | Background of the Applicant                                                                            |  | 37-39    |
| 12                   | Purpose of the Project                                                                                 |  | 40-273   |
| 13                   | Alternatives to the Project                                                                            |  | 274-275  |
| 14                   | Size of the Project                                                                                    |  | 276      |
| 15                   | Project Service Utilization                                                                            |  | 277--278 |
| 16                   | Unfinished or Shell Space                                                                              |  | N/A      |
| 17                   | Assurances for Unfinished/Shell Space                                                                  |  | N/A      |
|                      | <b>Service Specific:</b>                                                                               |  |          |
| 18                   | Medical Surgical Pediatrics, Obstetrics, ICU                                                           |  | N/A      |
| 19                   | Comprehensive Physical Rehabilitation                                                                  |  | N/A      |
| 20                   | Acute Mental Illness                                                                                   |  | N/A      |
| 21                   | Open Heart Surgery                                                                                     |  | N/A      |
| 22                   | Cardiac Catheterization                                                                                |  | N/A      |
| 23                   | In-Center Hemodialysis                                                                                 |  | N/A      |
| 24                   | Non-Hospital Based Ambulatory Surgery                                                                  |  | N/A      |
| 25                   | Selected Organ Transplantation                                                                         |  | N/A      |
| 26                   | Kidney Transplantation                                                                                 |  | N/A      |
| 27                   | Subacute Care Hospital Model                                                                           |  | N/A      |
| 28                   | Community-Based Residential Rehabilitation Center                                                      |  | N/A      |
| 29                   | Long Term Acute Care Hospital                                                                          |  | N/A      |
| 31                   | Clinical Service Areas Other than Categories of Service                                                |  | 279-281  |
| 32                   | Freestanding Emergency Center Medical Services                                                         |  | N/A      |
| 33                   | Birth Center                                                                                           |  | N/A      |
|                      | <b>Financial and Economic Feasibility:</b>                                                             |  |          |
| 34                   | Availability of Funds                                                                                  |  | 282-318  |
| 35                   | Financial Waiver                                                                                       |  | 319      |
| 36                   | Financial Viability                                                                                    |  | 320      |
| 37                   | Economic Feasibility                                                                                   |  | 321-324  |
| 38                   | Safety Net Impact Statement                                                                            |  | N/A      |
| 39                   | Charity Care Information                                                                               |  | 326      |
| 40                   | Flood Plain Information                                                                                |  | 31       |

### **Attachment 1**

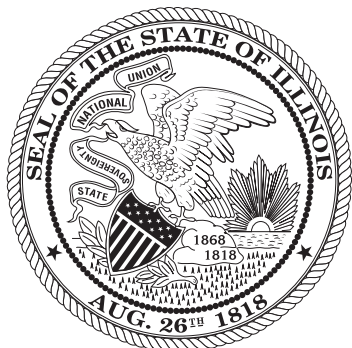
The Applicant is a not-for-profit corporation. Attached is a copy of the Certificate of Good Standing for the Applicant from the Illinois Secretary of State.



***To all to whom these Presents Shall Come, Greeting:***

*I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 26, 1965, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 12TH day of MARCH A.D. 2026 .***

Authentication #: 2607100372 verifiable until 03/12/2027

Authenticate at: <https://www.ilsos.gov>

*Alexi Giannoulis*

SECRETARY OF STATE

## **Attachment 2**

Attached is a copy of the deed evidencing the Applicant's ownership of the site.

900 N. 2<sup>nd</sup> Street, Rochelle, IL 61068

PIN: 24-24-251-001

D E E D

This Indenture, made this 30th day of April 1965 between the City of Rochelle, Illinois (a municipal corporation), and the City of Rochelle Hospital Board, parties of the first part; and Rochelle Community Hospital Association (a not-for-profit Illinois Corporation) of the City of Rochelle and State of Illinois as party of the second part.

WITNESSETH, that whereas the Council of the City of Rochelle by resolution has heretofore determined that the Rochelle Municipal Hospital is no longer needed for the purpose for which it was established, and

WHEREAS, the Mayor and City Council pursuant to Section 11-23-3 of Chapter 24 of the Illinois Revised Statutes has authorized the sale of the said hospital to the party of the second part pursuant to the terms of an agreement between the parties dated April 12, 1965, and

WHEREAS, the City of Rochelle Hospital Board at its meeting on April 26, 1965 passed a resolution consenting to the sale of the said real estate to the Rochelle Community Hospital Association, and authorizing its President and Secretary to sign this deed for and on behalf of the City of Rochelle Hospital Board.

NOW, THEREFORE, THIS INDENTURE WITNESSETH, that the parties of the first part, in consideration of One Dollar and other good and valuable consideration, the receipt whereof is hereby acknowledged, has granted, sold, and conveyed, and by these presents does grant, sell and convey unto the party of the second part, its successors and assigns forever, all the following described real estate, and all interest of the first parties therein, situated in the County of Ogle and State of Illinois:

Lots 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12 in Block 1 in MCCONAUGHY'S SECOND ADDITION to the City of ROCHELLE, in Ogle County, Illinois.

IN WITNESS WHEREOF, the City of Rochelle has caused this deed to be signed by its Mayor and its seal to be affixed by its Clerk and the City of Rochelle Hospital Board has caused this deed to be signed by its President and Secretary the day and year first above written.



ATTEST:

*[Signature]*  
Clerk

BY: *[Signature]*  
Mayor

CITY OF ROCHELLE, ILLINOIS

CITY OF ROCHELLE HOSPITAL BOARD

BY: *[Signature]* (SEAL)  
President

BY: *[Signature]* (SEAL)  
Secretary

BOOK 280 PAGE 1

24-24-251-001



-2-

STATE OF ILLINOIS )  
COUNTY OF OGLE ) SS

On this 30th day of April 1965, before me, a Notary Public, within and for said County, personally appeared H. L. Moore and R. M. DeCoursey, to me personally known, who being duly sworn, did say that they are respectively, the Mayor and City Clerk of the City of Rochelle, Illinois, and so named in the foregoing instrument, and that the seal affixed to said instrument is the corporate seal of the City of Rochelle, Illinois, a municipal corporation, and that said instrument was signed and sealed in behalf of said corporation by the authority of its City Council and that H. L. Moore and R. M. DeCoursey acknowledged said instrument to be the free act and deed of said Corporation.



*David K. Gues*  
Notary Public  
Ogle County

My Commission Expires: Aug. 24, 1967

STATE OF ILLINOIS )  
COUNTY OF OGLE ) SS

On this 30th day of April 1965, before me, a Notary Public within and for said County, personally appeared H. W. Loeigren and Mary Jeanne May to me personally known, who being by me duly sworn, did say that they are, respectively, the President and Secretary of the City of Rochelle Hospital Board, and so named in the foregoing instrument, and said instrument was signed and sealed in behalf of said organization by the authority of its Board of Directors, and said H. W. Loeigren and Mary Jeanne May acknowledged said instrument to be the free act and deed of said organization.



*David K. Gues*  
Notary Public  
Ogle County

My Commission Expires: Aug. 24, 1967

372650

STATE OF ILLINOIS )  
OGLE COUNTY ) SS

RECORDER'S  
OFFICE

FILED FOR RECORD THE 12th DAY OF  
MAY A.D. 1965 AT 2:20  
O'CLOCK P.M. AND RECORDED IN BOOK 260  
OF 212 PAGE 1  
DEPUTY RECORDER

### Attachment 3

Below is a copy of the license for the facility. A copy of the Certificate of Good Standing is provided in Attachment 1. The facility is owned and operated by the Applicant.

|                                                                                                                                                                                                                                                     |                         |                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------|
|                                                                                                                                                                    |                         |                                                                                               |
| <b>ILLINOIS DEPARTMENT OF<br/>PUBLIC HEALTH</b>                                                                                                                                                                                                     |                         |                                                                                               |
| <b>HF133326</b>                                                                                                                                                                                                                                     |                         |                                                                                               |
| <b>LICENSE, PERMIT, CERTIFICATION, REGISTRATION</b>                                                                                                                                                                                                 |                         |                                                                                               |
| <small>The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.</small> |                         |                                                                                               |
| <b>Sameer Vohra, MD,JD,MA</b>                                                                                                                                                                                                                       |                         | <small>Issued under the authority of<br/>the Illinois Department of<br/>Public Health</small> |
| <b>Director</b>                                                                                                                                                                                                                                     |                         |                                                                                               |
| <small>EXPIRATION DATE</small>                                                                                                                                                                                                                      | <small>CATEGORY</small> | <small>I.D. NUMBER</small>                                                                    |
| <b>6/30/2026</b>                                                                                                                                                                                                                                    |                         | <b>0002022</b>                                                                                |
| <b>Critical Access Hospital</b>                                                                                                                                                                                                                     |                         |                                                                                               |
| <b>Effective: 07/01/2025</b>                                                                                                                                                                                                                        |                         |                                                                                               |
| <b>Rochelle Community Hospital</b><br><b>900 N 2nd St</b><br><b>Rochelle, IL 61068</b>                                                                                                                                                              |                         |                                                                                               |
| <small>The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4024001 2M 4/24</small>                                                                                                           |                         |                                                                                               |

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

Exp. Date 6/30/2026

Lic Number 0002022

Date Printed 3/27/2025

Rochelle Community Hospital

900 N 2nd St  
Rochelle, IL 61068

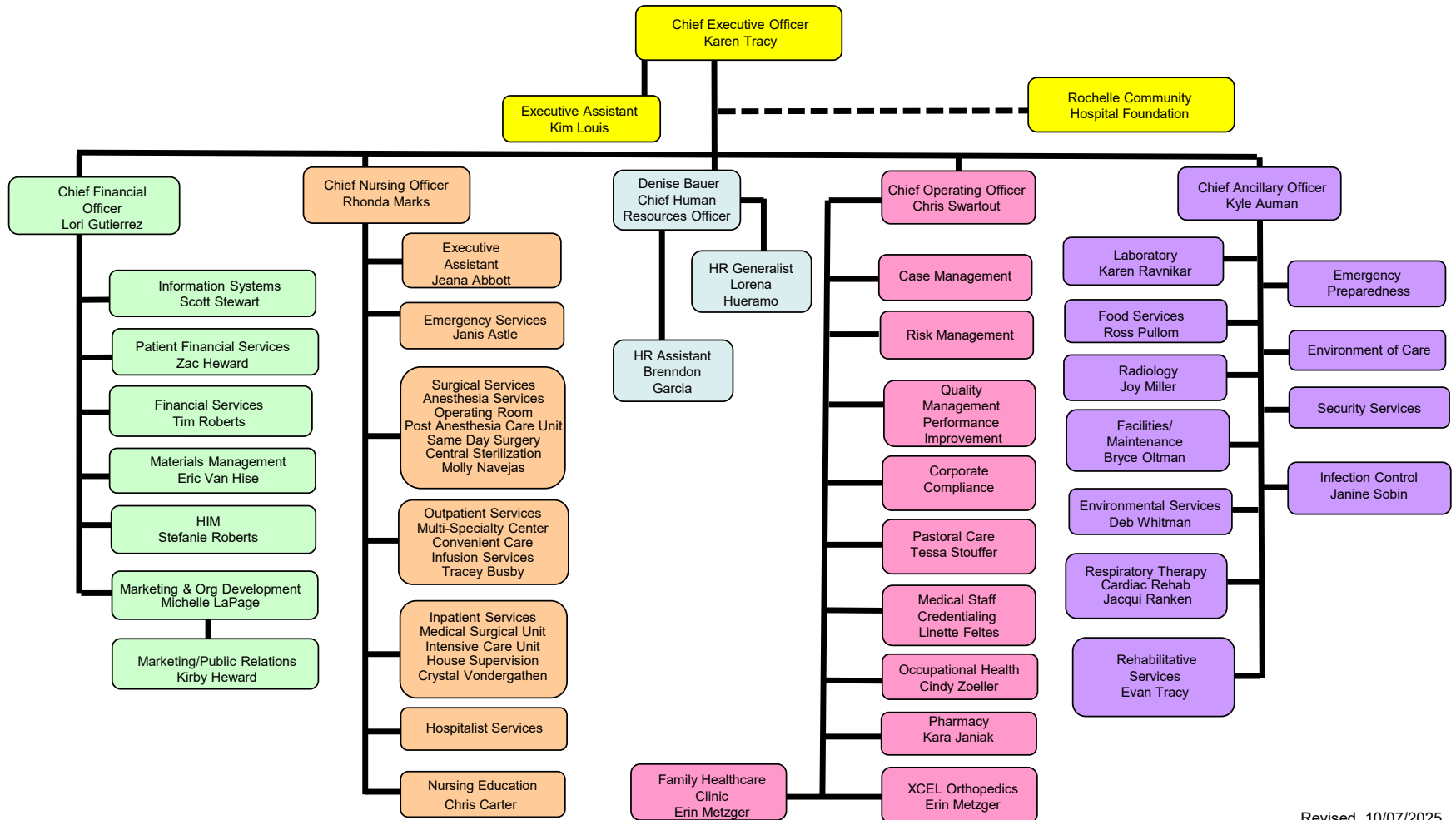
**FEE RECEIPT NO.**

#### **Attachment 4**

As referenced in Attachment 3, the facility is owned and operated by the Applicant. A copy of an organizational chart for the Applicant is included in Attachment 4. Although the Applicant does not have any subsidiaries or parent companies, its Board of Directors holds certain governance authorities in relation to Rochelle Community Hospital Foundation (“Foundation”) — a separate legal entity and non-profit organization — including director appointment and other oversight mechanisms.

# Rochelle Community Hospital Association Organizational Chart

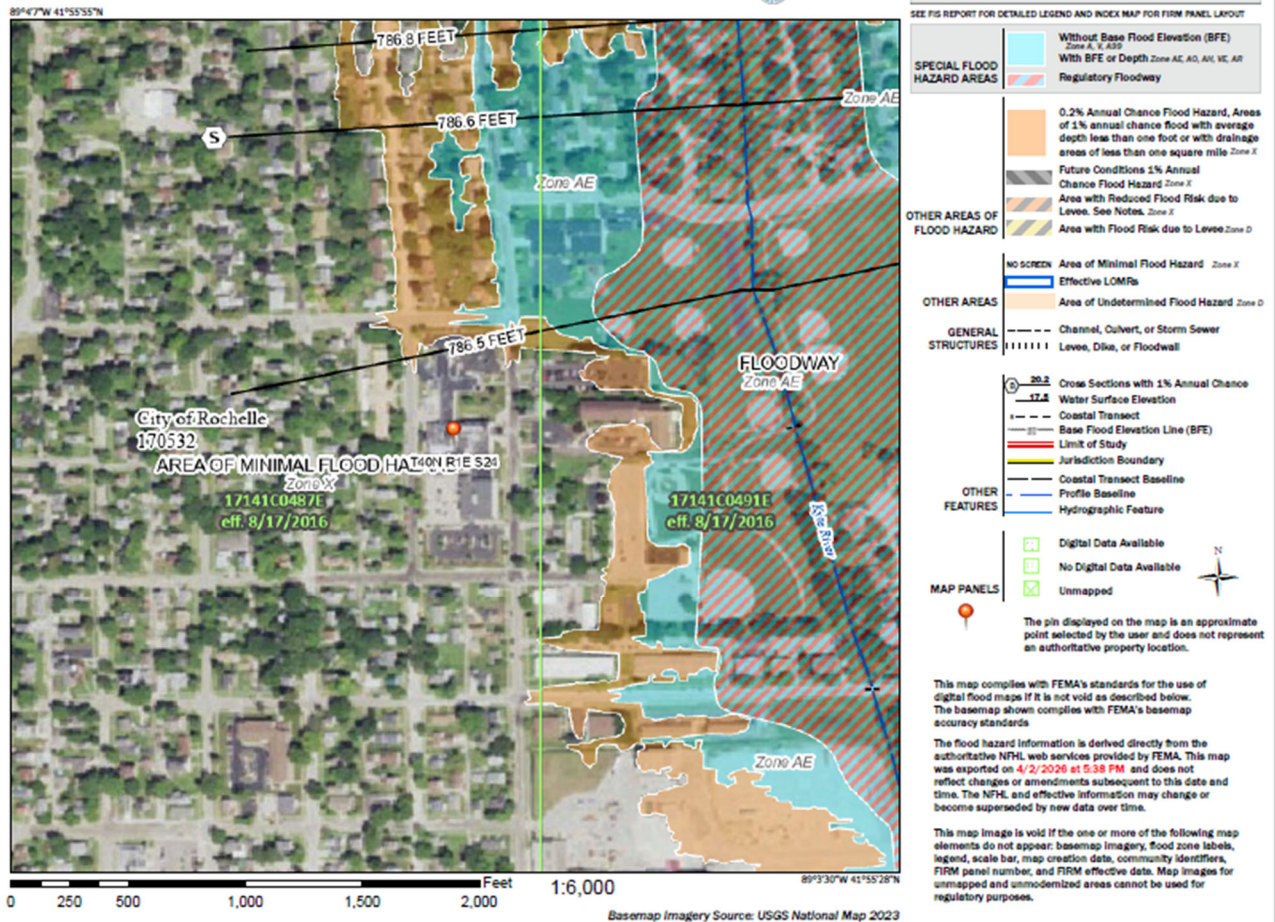
Board Chair: Brent Ohlinger  
Chief Medical Staff: Dr. Jason Popp  
Auxiliary President: Maria Van Hise



## Attachment 5

As shown in the below FEMA National Flood Hazard Layer map, the project site is not located in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain, and the project complies with the requirements of Illinois Executive Order #2006-05.

### National Flood Hazard Layer FIRMette



## **Attachment 6**

The Applicant has submitted a request to the Illinois Department of Natural Resources regarding compliance with the requirements of the Historic Resources Preservation Act. The Applicant will forward the Historic Preservation Act determination in relation to this project upon receipt from the agency.

### Attachment 7

| Project Costs and Sources of Funds                                                                                                             |                   |                   |                   |
|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------|-------------------|
| USE OF FUNDS                                                                                                                                   | CLINICAL          | NONCLINICAL       | TOTAL             |
| Preplanning Costs                                                                                                                              | 215,879           | 258,076           | 473,955           |
| Site Survey and Soil Investigation                                                                                                             | 181,654           | 213,246           | 394,900           |
| Site Preparation                                                                                                                               | 1,204,171         | 1,413,592         | 2,617,763         |
| Off Site Work                                                                                                                                  |                   | 56,733            | 56,733            |
| New Construction Contracts                                                                                                                     | 13,174,633        | 15,422,395        | 28,597,028        |
| Modernization Contracts                                                                                                                        |                   | 7,585,080         | 7,585,080         |
| Contingencies                                                                                                                                  | 2,130,469         | 2,750,985         | 4,881,454         |
| Architectural/Engineering Fees                                                                                                                 | 1,138,776         | 1,336,824         | 2,475,600         |
| Consulting and Other Fees                                                                                                                      | 94,300            | 110,700           | 205,000           |
| Movable or Other Equipment (not in construction contracts)                                                                                     | 832,000           | 90,000            | 922,000           |
| Bond Issuance Expense (project related)                                                                                                        |                   |                   | -                 |
| Net Interest Expense During Construction (project related)                                                                                     |                   |                   | -                 |
| Fair Market Value of Leased Space or Equipment                                                                                                 |                   |                   | -                 |
| Other Costs to Be Capitalized                                                                                                                  | 170,200           | 199,800           | 370,000           |
| Acquisition of Building or Other Property (excluding land)                                                                                     |                   |                   | -                 |
| <b>TOTAL USES OF FUNDS</b>                                                                                                                     | <b>19,142,082</b> | <b>29,437,431</b> | <b>48,579,513</b> |
| SOURCE OF FUNDS                                                                                                                                | CLINICAL          | NONCLINICAL       | TOTAL             |
| Cash and Securities                                                                                                                            | 19,142,082        | 29,437,431        | 48,579,513        |
| Pledges                                                                                                                                        |                   |                   |                   |
| Gifts and Bequests                                                                                                                             |                   |                   |                   |
| Bond Issues (project related)                                                                                                                  |                   |                   |                   |
| Mortgages                                                                                                                                      |                   |                   |                   |
| Leases (fair market value)                                                                                                                     |                   |                   |                   |
| Governmental Appropriations                                                                                                                    |                   |                   |                   |
| Grants                                                                                                                                         |                   |                   |                   |
| Other Funds and Sources                                                                                                                        |                   |                   |                   |
| <b>TOTAL SOURCES OF FUNDS</b>                                                                                                                  | <b>19,142,082</b> | <b>29,437,431</b> | <b>48,579,513</b> |
| NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. |                   |                   |                   |

### **Attachment 7 – Itemization of Line-Items**

| <b>USE OF FUNDS</b>                                                                       | <b>TOTAL</b>               |
|-------------------------------------------------------------------------------------------|----------------------------|
| Preplanning Costs                                                                         | 473,955                    |
| -Development and feasibility studies and plans                                            |                            |
| -Legal fees                                                                               |                            |
| Site Survey and Soil Investigation                                                        | 394,900                    |
| -Testing and site survey                                                                  |                            |
| -Soil borings layout-staking                                                              |                            |
| Site Preparation                                                                          | 2,617,763                  |
| -Site excavation, site concrete, demo of existing building, utility relocation            |                            |
| Off Site Work                                                                             | 56,733                     |
| -Offsite road reconstruction                                                              |                            |
| New Construction Contracts                                                                | 28,597,028                 |
| -New addition building cost                                                               |                            |
| Modernization Contracts                                                                   | 7,585,080                  |
| -Renovation of existing buildings                                                         |                            |
| Contingencies                                                                             | 4,881,454                  |
| -Cost allowance for unforeseen circumstances                                              |                            |
| Architectural/Engineering Fees                                                            | 2,475,600                  |
| -Preliminary design, schematic design, design development, construction document services |                            |
| Consulting and Other Fees                                                                 | 205,000                    |
| -CON processing fee                                                                       |                            |
| -Legal and other related consulting fees                                                  |                            |
| Movable or Other Equipment (not in construction contracts)                                | 922,000                    |
| -Moving costs associated with relocating lab and radiology equipment                      |                            |
| -Purchase and installation of new Nuclear Medicine machine                                |                            |
| Other Costs to Be Capitalized                                                             | 370,000                    |
| -Asbestos abatement                                                                       |                            |
|                                                                                           |                            |
|                                                                                           |                            |
|                                                                                           | <b>Total: \$49,579,513</b> |



## **Attachment 8**

Financial commitment will occur after permit issuance.

Attachment 8

### Attachment 9 – Cost Space Requirements

| Dept. / Area                                                                                                   | Cost***           | Gross Square Feet |               | Amount of Proposed Total Gross Square Feet That Is: |               |          |                |
|----------------------------------------------------------------------------------------------------------------|-------------------|-------------------|---------------|-----------------------------------------------------|---------------|----------|----------------|
|                                                                                                                |                   | Existing          | Proposed**    | New Const.**                                        | Modernized**  | As Is    | Vacated Space* |
| <b>CLINICAL</b>                                                                                                |                   |                   |               |                                                     |               |          |                |
| Emergency Department                                                                                           | 7,088,111         | 4989              | 7184          | 7184                                                | -             | -        | 4989           |
| General Radiology                                                                                              | 6,756,363         | 5593              | 6851          | 6851                                                | -             | -        | 5593           |
| Lab                                                                                                            | 3,151,036         | 2678              | 3485          | 3485                                                | -             | -        | 2678           |
| Convenient Care                                                                                                | 2,146,572         | 1829              | 2120          | 2120                                                | -             | -        | 1829           |
| <b>Total Clinical</b>                                                                                          | <b>19,142,082</b> | <b>15,089</b>     | <b>19,640</b> | <b>19,640</b>                                       | <b>-</b>      | <b>-</b> | <b>15,089</b>  |
| <b>NON-CLINICAL</b>                                                                                            |                   |                   |               |                                                     |               |          |                |
| Administrative                                                                                                 | 10,629,755        | -                 | 9843          | -                                                   | 9843          | -        | -              |
| Patient Reg/Circ/Staff/Loading Dock                                                                            | 16,120,609        | -                 | 14,893        | 13,568                                              | 1325          | -        | -              |
| Material Management                                                                                            | 2,687,067         | -                 | 2802          | -                                                   | 2802          | -        | -              |
| <b>Total Non-Clinical</b>                                                                                      | <b>29,437,431</b> | <b>-</b>          | <b>27,538</b> | <b>13,568</b>                                       | <b>13,970</b> | <b>-</b> | <b>-</b>       |
| <b>TOTAL</b>                                                                                                   | <b>48,579,513</b> |                   | <b>47,178</b> | <b>33,208</b>                                       | <b>13,970</b> | <b>-</b> | <b>15,089</b>  |
| APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. |                   |                   |               |                                                     |               |          |                |

\*Vacated space will be used for administrative and storage space.

\*\*Includes circulation and ancillary support space

\*\*\*Includes other project costs assigned to clinical use or non-clinical use, as applicable, including contingency costs, architectural/engineering fees, etc.

### **Attachment 11**

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

None other than the hospital. A copy of the hospital license is included in Attachment 3, and a copy of the certificate of accreditation is included in Attachment 11.

- 2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.**

Not applicable.

- 3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.**

- a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.**

By the signatures on the certification pages of this application, the Applicant attests that no adverse action has been taken against the hospital during the three years prior to filing this application.

- b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.**

Not applicable.

- c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.**

Not applicable.

- d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.**

Not applicable.

- e. **A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.**

Not applicable.

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

By the signatures provided on the certification pages, the Applicant authorizes the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health (“IDPH”) access to any documents necessary to verify any information submitted, including, but not limited to, official records of IDPH or other State agencies, licensing or certification records of other states, and records of nationally recognized accreditation organizations.

- 5. **If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.**

Not applicable.

# Rochelle Community Hospital

Rochelle, IL

has been Accredited by

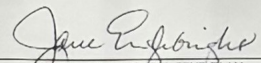


## The Joint Commission

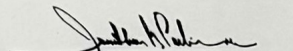
Which has surveyed this organization and found it to meet the requirements for the  
Critical Access Hospital Accreditation Program

September 22, 2023

Accreditation is customarily valid for up to 36 months.

  
Jane Englebright, PhD, RN, CENP, FAAN  
Chair, Board of Commissioners

ID #351918  
Print/Reprint Date: 01/12/2024

  
Jonathan B. Perlun, MD, PhD, MSHA, MACP, FACMI  
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at [www.jointcommission.org](http://www.jointcommission.org).



## **Attachment 12 - Purpose of Project**

### **Background, Planning Area/Service Area, & Identified Community Health Needs**

Rochelle Community Hospital (“RCH”) is a 16-bed Critical Access Hospital (“CAH”) located in Rochelle, Illinois, a community of approximately 9,500 residents in Ogle County, 108 miles west of Chicago. The service area is federally designated as both a Primary Care and Mental Health Health Professional Shortage Area (“HPSA”) and is recognized as rural by the Federal Office of Rural Health Policy.<sup>1</sup> These designations underscore the limited availability of healthcare resources and the essential role RCH plays in ensuring access to care.

While physically located in Rochelle, RCH serves a broader regional population, including Ogle and Lee Counties and portions of DeKalb County. As documented in RCH’s 2025 Community Health Needs Assessment (“CHNA”),<sup>2</sup> approximately 70% of patient volume originates from Rochelle and more than 90% from Ogle and Lee Counties. The service area reflects a diverse demographic profile with significant variation in healthcare needs. Notably, while older adults represent 20% of the population, the cohort aged 75 and older is the fastest growing segment, with projected growth of 16% over five years, indicating increasing demand for complex and acute care services.

Consistent findings from the RCH CHNA, supporting qualitative and quantitative analyses,<sup>3</sup> and county-level assessments in Ogle and Lee Counties<sup>4</sup> identify three primary and interrelated community health priorities:

- Behavioral health, including mental health and substance use disorders
- Access to healthcare services
- Chronic disease and obesity

These needs are particularly pronounced in this rural and underserved region, where provider shortages, limited specialty services, and transportation barriers constrain timely access to care and place increased reliance on RCH as a primary point of service.

### **RCH Campus History, Existing Conditions, and Operational Constraints**

RCH was established in 1913, with the current campus at 900 North Second Street developed in 1944 and subsequently expanded over several decades. Key additions include a 1968 expansion housing the existing Laboratory and Radiology Departments, a 1990s addition for Convenient Care, a 2003 addition for the existing Emergency Department, and a medical office building constructed in 2016. While these expansions have enabled RCH to grow with its community, they have also resulted in a facility composed of multiple construction vintages integrated over more than 80 years (see image below).

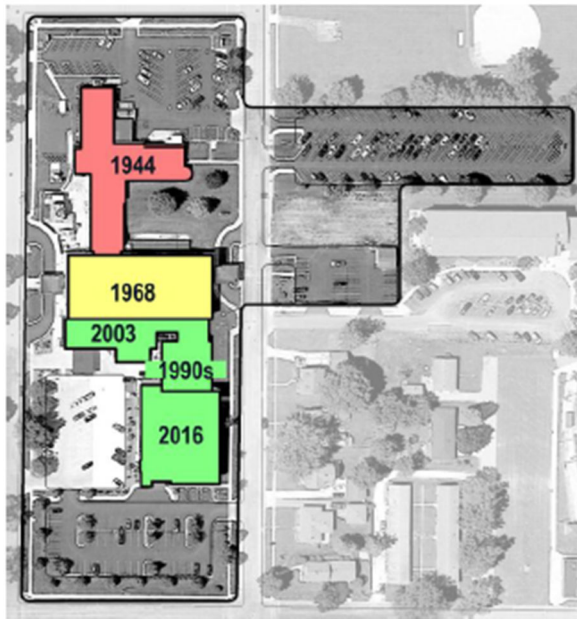
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<sup>1</sup> HRSA HPSA Designation and FORHP Rural Designation, **Attachment 12-A**.

<sup>2</sup> RCH 2025 CHNA, **Attachment 12-B**.

<sup>3</sup> April 2022 report detailing focus group findings, key stakeholder interviews, and secondary data analysis, included as **Attachment 12-C**.

<sup>4</sup> Ogle County 2025 CHNA and IPLAN 2020, **Attachment 12-D**, and Lee County Health Department IPLAN 2021 and CHNA and 2025 CHNA, **Attachment 12-E**.



This incremental development has created significant infrastructure challenges, including aging and incompatible electrical, HVAC, plumbing, and fire protection systems. A 2023 independent assessment by Kahler Slater confirmed that much of the facility’s infrastructure has exceeded its useful life and requires substantial upgrade or replacement.

The assessment further identified critical deficiencies in key clinical departments central to emergency and diagnostic care delivery. The existing Emergency Department (“ED”) is undersized and misaligned with current standards, with inefficient circulation patterns, compromised patient access and security, and conflicts between ambulance and staff traffic. Similarly, the Radiology Department is undersized, lacks appropriate support spaces and patient privacy, and cannot fully support modern imaging equipment requirements due to system limitations. The Laboratory Department faces comparable constraints, including undersized clinical areas, inadequate storage, temperature control issues, and limited capacity to support current and future diagnostic needs.

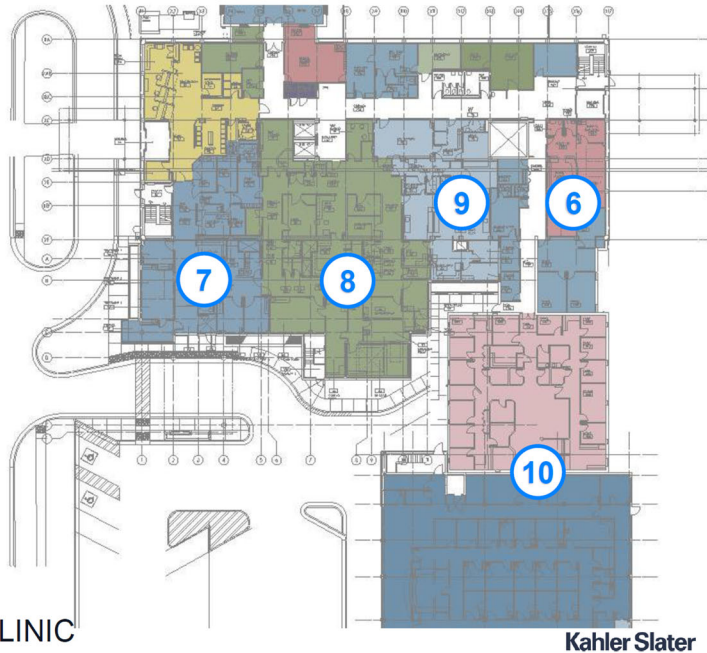
While additional facility challenges were identified, these departments were prioritized due to their direct impact on patient safety, access, care quality, and regulatory compliance.

A floor plan showing the layout of existing departments is provided below.



## Existing Department Plan – First Floor

- ⑥ INFUSION & ADMIN
- ⑦ EMERGENCY
- ⑧ IMAGING
- ⑨ LABORATORY
- ⑩ CONVENIENT CARE & CLINIC



### **Proposed Project**

The proposed project is a strategically developed modernization initiative designed to address the hospital's most critical infrastructure and operational deficiencies while directly responding to identified community health needs.

At the core of the project is the relocation and expansion of the ED from six to ten treatment stations, appropriately sized to meet current volumes, projected demand, and increasing behavioral health needs. Three of the four additional stations will be purpose-built to safely serve patients experiencing mental health crises, reflecting the growing demand for acute behavioral health services.

Currently, ED volumes frequently necessitate overflow strategies, including holding lower-acuity patients and extended stays for individuals awaiting transfer to facilities offering specialized services. These conditions contribute to prolonged wait times, inefficiencies in patient flow, and capacity constraints. Behavioral health visits have increased in recent years, including patients with severe mental illness, substance use disorders, and co-occurring conditions. Limited availability of behavioral health providers (see image below), inpatient beds, and step-down services in Rochelle and surrounding rural communities—combined with transportation barriers—results in the ED serving as the primary access point for patients in acute mental health crisis, further reinforcing the need for expanded and specialized ED capacity.

The existing ED lacks dedicated space, privacy, and appropriate design to support extended behavioral health stays, resulting in overcrowding and the use of non-ideal treatment areas. RCH treats more than 50 patients per month with primary behavioral health diagnoses, many of whom require extended ED stays due to limited access to inpatient psychiatric services. RCH is not equipped nor licensed to provide inpatient psychiatric care, and patients often remain in the ED



while placement is arranged. The addition of 4 stations in the ED will improve capacity, support efficient triage, and reduce delays in care.

To support emergency services and maintain stroke readiness, the Radiology Department will be relocated adjacent to the ED, allowing for improved care coordination and replacement of an outdated nuclear medicine machine that could not otherwise be accommodated within the size constraints of the current department. The Laboratory Department will also be relocated and expanded to provide adequately sized clinical and support spaces that enhance workflow efficiency and support modern diagnostic capabilities. In addition, the existing Convenient Care will be relocated adjacent to the ED, enabling shared staffing for triage functions and improving access to walk-in care for non-emergent conditions. The project further reconfigures campus access to improve wayfinding and operational efficiency by establishing a clearly defined primary public entrance for hospital services and a separate access point dedicated to materials management and deliveries. In addition, the project will proactively address the hospital's outdated infrastructure systems while ensuring compliance with current code requirements, 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 long-term viability of the hospital facility.

The first phase of the project includes removal of the 1944 portion of the campus to allow for construction of a new structure that will house 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. Floor plans of the proposed project are included as **Attachment 12-F**.

Collectively, these improvements will modernize critical hospital infrastructure, enhance patient access and safety, and ensure that RCH remains a sustainable and vital healthcare provider in the community, positioned to meet current and future community needs.

### **Community Support**

The proposed project has already garnered significant community support, as evidenced by the numerous letters of support submitted in connection with RCH's related grant funding request. Letters of support are included as **Attachment 12-G**.

Further demonstrating its merit, RCH was recently notified by Congressman Darin LaHood that its \$4,000,000 funding request has been selected for consideration as part of 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.



# Find Shortage Areas by Address

Enter an address to determine if it is located in a designated shortage area

(<https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation>).

## Use this tool to:

- › Determine if a specific address is located in a HPSA Geographic, HPSA Geographic High Needs, Population Group HPSA, or an MUA/P designated area



Contact Information: SDB@hrsa.gov

(mailto:SDB@hrsa.gov)

HPSA Data as of 05/06/2026  
MUA Data as of 05/06/2026

**Address**  
900 n. 2nd street , rochelle, IL, 61068

**Standardized address**  
900 N 2nd St, Rochelle, Illinois, 61068

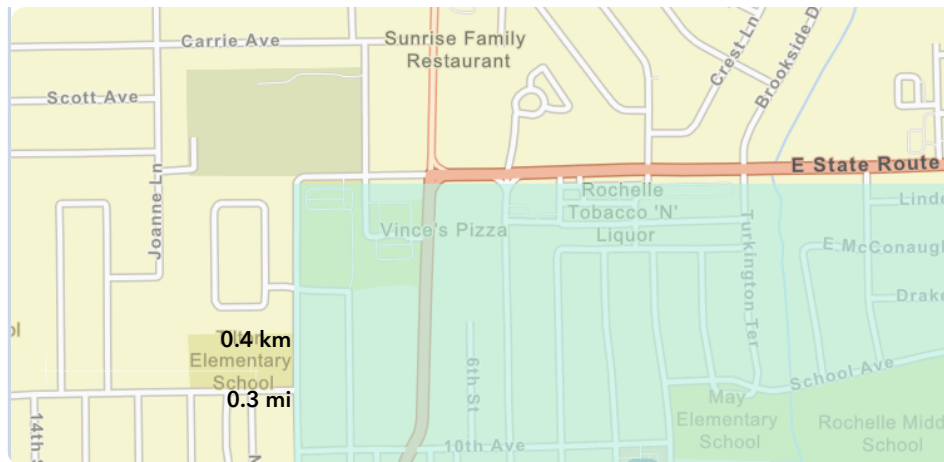
+

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**Note:** The address you entered is geocoded and then compared against the HPSA and MUA/P data in data.HRSA.gov. Due to geoprocessing limitations, the designation cannot be guaranteed to be 100% accurate and does not constitute an official determination. Please consult your program of interest to determine if a HPSA in "Proposed For Withdrawal" status will provide eligibility.

[+] More about this address

**In a Dental Health HPSA:** ✗ No

**In a Mental Health HPSA:** ✓ Yes

**HPSA Name:** LI-Northern IL MHCA

**ID:** 7178554361

**Designation Type:** HPSA Population

**Status:** Designated

**HPSA Score:** 17

**Designation Date:** 02/18/2026

**Last Update Date:** 02/18/2026

**HPSA Name:** Ogle County

**ID:** 7174560105

**Designation Type:** Geographic HPSA

**Status:** Proposed For Withdrawal

**HPSA Score:** 16

**Designation Date:** 12/20/2021

**Last Update Date:** 09/22/2025

**In a Primary Care HPSA:** ✓ **Yes**

**HPSA Name:** Ogle County

**ID:** 1178770910

**Designation Type:** Geographic HPSA

**Status:** Designated

**HPSA Score:** 8

**PC MCTA Score:** 11

**Designation Date:** 12/06/2024

**Last Update Date:** 09/10/2025

**In a MUA/P:** ✗ **No**

**HRSA**  
Data Warehouse

Contact Us for Support (<mailto:data@hrsa.gov>)

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## Location

### Report Address:

900 North 2nd Street, Rochelle,  
Illinois 61068

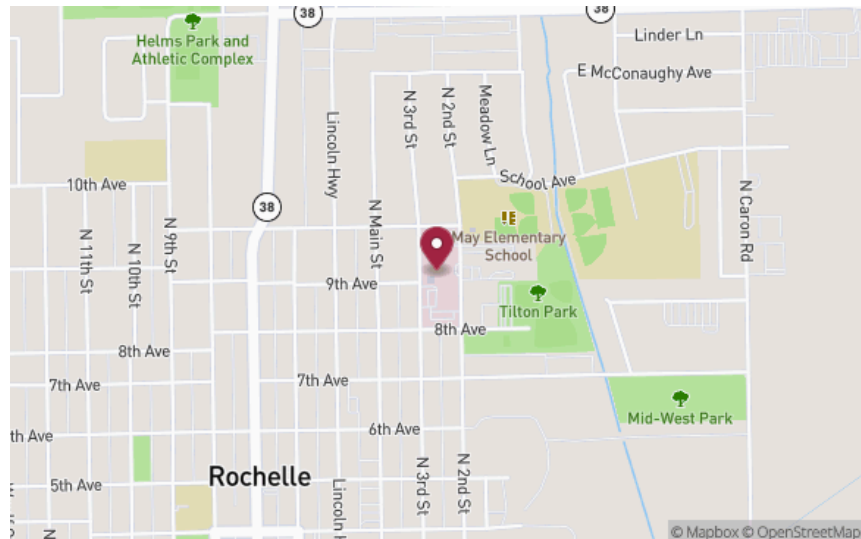
**Latitude:** 41.92832

**Longitude:** -89.06354

### Census Tract:

17141961100 (2020)

**County:** Ogle County, IL



## Common Rural Definitions

### Core Based Statistical Areas (CBSAs), 2025

Data Source: [2025 TIGER/Line](#), U.S. Census Bureau

- CBSA Type: Micropolitan
- CBSA Name: Rochelle, IL Micro Area
- CBSA ID: 40300

### Urban Areas, 2020

Data Source: [2025 TIGER/Line](#), U.S. Census Bureau

Located within an Urban Area.

- Urban Area Name: Rochelle, IL Urban Area
- UA Number: 75583

### Federal Office of Rural Health Policy (FORHP) defined rural areas

Data Source: List provided by the Federal Office of Rural Health Policy - updated 9/12/2025

Ogle County, IL has been designated by FORHP as rural.

### Frontier and Remote Area (FAR)

by 2020 census tract

- Not located in a Frontier and/or Remote area.

Data Source: [Frontier and Remote Area Codes](#),  
[Economic Research Service](#)

### Rural-Urban Commuting Areas (RUCAs)

by 2020 census tract

Data Source: [Rural-Urban Commuting Area Codes, Economic Research Service](#)

- RUCA Code: 4.0
- Primary Description: Micropolitan core: primary flow is within an urban area of 10,000 to 49,999 people (micro UA)

### Rural-Urban Continuum Codes (RUCCs) 2023

Data Source: [Rural-Urban Continuum Codes, Economic Research Service](#)

RUCCs are assigned at the county level.

Information for Ogle County

- RUCC Code: 6
- RUCC Description: Nonmetro - Urban population of 5,000 to 20,000, adjacent to a metro area

### Urban Influence Codes (UICs) 2024

Data Source: [Urban Influence Codes, Economic Research Service](#)

Information for Ogle County

- Urban Influence Code: 2
- UIC Description: Micropolitan, adjacent to a large metro area

### Census 2020, Percent Rural

Data Source: [Urban and Rural](#), U.S. Census Bureau

Information for Ogle County

- Percent of County Population that is Rural: 67.87

## Program Eligibility

The information provided by this service addresses only the rural aspect of a program's requirements. Your *Am I Rural?* report is not a guarantee of your rural status. Please check with the program contacts directly to verify your eligibility for specific federal programs.

| Program                                  | Rural? | Explanation                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CMS - Rural Health Clinics (RHC) Program | YES    | <a href="#">CMS interim guidance</a> considers a location to meet the rural location requirement for the RHC program if it is outside of an urbanized area in the 2010 Census Bureau data OR if it is outside of an urban area in the 2020 Census Bureau data. <ul style="list-style-type: none"><li>• This location is outside of 2010 Urbanized Areas</li></ul> |

## Shortage Designations

| Area Type                                             | Present? | Details                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Primary Care Health Professional Shortage Area (HPSA) | YES      | <b>Name:</b> Ogle County<br><b>ID:</b> 1178770910<br><b>Type:</b> Geographic HPSA<br><b>Score:</b> 8<br><b>Date of Designation:</b> December 6, 2024<br><b>Last Update:</b> September 10, 2025                                                                                                                                                                                                                                                                   |
| Dental Care HPSA                                      | NO       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Mental Health HPSA                                    | YES      | <b>Name:</b> Ogle County<br><b>ID:</b> 7174560105<br><b>Type:</b> Geographic HPSA<br><b>Score:</b> 16<br><b>Date of Designation:</b> December 20, 2021<br><b>Last Update:</b> September 22, 2025<br><br><b>Name:</b> LI-Northern IL MHCA<br><b>ID:</b> 7178554361<br><b>Type:</b> HPSA Population<br><b>Population:</b> Low Income Population HPSA<br><b>Score:</b> 17<br><b>Date of Designation:</b> February 18, 2026<br><b>Last Update:</b> February 18, 2026 |
| Medically Underserved Area/Population                 | NO       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

For data sources and definitions, see the [Rural Classifications](https://www.ruralhealthinfo.org/am-i-rural/help#classification) (<https://www.ruralhealthinfo.org/am-i-rural/help#classification> help section).



# Community Health Needs Assessment Report

## Rochelle Community Hospital

Rochelle, Illinois

Published 04/30/2025

### Introduction

Rochelle Community Hospital is a 17-bed critical access hospital owned and operated by Rochelle Community Hospital Association in Rochelle, Illinois. Rochelle Community Hospital Association was created in 1965 as the culmination of fifty years of effort to provide a consistent healthcare resource for the city and surrounding community.

At Rochelle Community Hospital, we believe care is more than helping you heal – it's partnering with you throughout life to help you protect your health, meet your goals and live your best life!

**Our Mission** is to improve the health of our community by providing high quality care with competence, excellence and compassion.

**Our vision** is to provide local community-based health and wellness services focused on a safe and high quality healthcare experience and to be the hospital of choice for patients, physicians and employees.

As your community hospital, we are committed to a holistic approach to your well-being called 360° Care. This hospital-wide initiative integrates and enhances every aspect of your care, no matter what the service or stage of life. From primary care to convenient care and specialty services, we are proud to bring the best healthcare to the place we call home and the people we call neighbors. We have served the community for generations and look forward to serving for generations to come.

At Rochelle Community Hospital, you can count on treatment that focuses on you – encircling, helping and supporting you with care from a staff that works together on your behalf. We offer a variety of specialized outpatient services to help meet your healthcare needs.

- Anesthesiology
- Cardiac Rehabilitation
- Convenient Care
- Imaging and Radiology
- Emergency Services
- Hospitalist Program
- Infusion Services
- Laboratory
- Occupational Health
- XCEL Orthopedics
- Physical Therapy & Rehabilitation
- Pulmonary Rehabilitation & Respiratory Therapy
- Stroke Care
- Surgery
- Swing Bed Program

In addition, through our Multi-Specialty Clinic, we provide the following services to the community.

- Cardiology
- Dermatology
- Hematology/Oncology
- Nephrology (kidney care)
- Neurology
- Podiatry
- Surgery

Rochelle Community Hospital is pleased to submit this Community Health Needs Assessment. We do so both as a matter of compliance with Section 501(r)(3) of the Internal Revenue Code, as mandated in the Patient Protection and Affordable Care Act, and as an obligation to those we serve. As an organization, we view this survey as an opportunity to improve our community service and continuously focus on meeting the changing health care needs of our community.

Consistent with the requirements of Section 501(r)(3), the Community Health Needs Assessment Report is organized as follows:

- Our Community
- Community Health Needs Assessment Methodology
- Prioritized Community Health Needs
- Health Resources

### **Our Community**

Although Rochelle Community Hospital is in Rochelle, Illinois, we define our “community” as a broader area that includes Ogle and Lee Counties, as well as a portion of DeKalb County. Throughout this document, any reference to “community” is meant to indicate this broader service area.

Within this broader community, approximately seventy percent of our patient volume comes from residents of the city of Rochelle and over ninety percent comes from residents of Ogle and Lee Counties. Because of the large proportion of our community that resides within this limited area and because we believe it is representative of our larger community, we limited our data collection to Ogle and Lee Counties.

The city of Rochelle is home to approximately 10,000 people and is located about one hour west of Chicago. Rochelle offers an experience for all tastes – from relaxation to exhilaration – with that hometown feel.

Rochelle is bustling with activity in the summer months with a monthly Outdoor Market, Concerts & Movies in the parks, golf, swimming, hiking and more. The beauty of fall brings Hay Day, a trail of decorated haybales throughout our community. A Classic Downtown Christmas is celebrated in December with a fully lit parade and bustling Downtown. Spring boasts the Vince

Carney Community Theater’s Spring production, our annual Irish Hooley, a community-wide Easter egg hunt, and our Cinco de Mayo celebration.

Our newest Downtown addition, Kennay Farms Distilling offers a bit of history along with tastes of the country with craft beer and spirits and the educational tour experience. Chicagoland Skydiving Center is jumping with activity year-round from skydiving spring through fall and the addition of the Flight Deck Bar and Grill, open year-round. Located on either side of the BNSF and Union Pacific Railroad tracks, Rochelle’s Railroad Park is a sight to see for railfans. The park features a gift shop and a gazebo for train-spotting. Take a stroll through our historic downtown and visit the 1918 Standard Oil Filling Station and the Flagg Township Historical Museum.

In 2020, the U.S. Census Bureau conducted the nation’s most recent census and published that data by state, county, and city. Similarly, the Population Health Institute collects and reports health data and demographic data by county on an annual basis. U.S. census data are from the 2020 census, with some figures being extrapolated to 2024 and others being actual data from subsequent years. Population Health Institute data is as of December 2024.

|                                          | <b>Illinois</b> | <b>Ogle County</b> | <b>Lee County</b> |
|------------------------------------------|-----------------|--------------------|-------------------|
| Population                               | 12,549,689      | 51,265             | 33,654            |
| Age < 18                                 | 21.6%           | 22.1%              | 19.5%             |
| Age 65+                                  | 17.6%           | 20.4%              | 21.7%             |
| Caucasian                                | 76.0%           | 95.6%              | 91.0%             |
| African American                         | 14.6%           | 1.5%               | 5.8%              |
| American Indian                          | 0.6%            | 0.5%               | 0.5%              |
| Asian                                    | 6.3%            | 0.7%               | 0.9%              |
| Hispanic                                 | 19.0%           | 12.1%              | 7.8%              |
| High school graduate                     | 90.3%           | 91.0%              | 90.5%             |
| Bachelor’s Degree or Higher              | 37.2%           | 24.0%              | 19.4%             |
| Person’s Without Health Insurance        | 7.3%            | 6.1%               | 5.6%              |
| People in Poverty                        | 11.6%           | 9.2%               | 10.1%             |
| Children in Poverty                      | 15.7%           | 11.2%              | 13.5%             |
| Children Eligible for Free/Reduced Lunch | 46.3%           | 33.4%              | 45.9%             |
| Unemployment                             | 4.6%            | 4.0%               | 4.8%              |
| Median Household Income                  | \$81,702        | \$79,244           | \$68,459          |

Related to the Illinois figures in this table, it’s worth noting that approximately 9.5 million people, or 75 percent of the state’s population, live in the greater Chicago metropolitan area. Therefore, the state averages are heavily biased towards trends and patterns in the Chicago area.

Our community has approximately the same percentage of adolescents but a higher percentage of elderly individuals than the state average. Ogle and Lee Counties have approximately the same high school graduation rate as the state, but they have significantly smaller percentages of college

graduates. This emphasizes the blue-collar nature of our community, with agriculture being the most common local occupation.

Compared to the state averages, our community has relatively low rates of people living without insurance, people in poverty, children in poverty, and children eligible for free lunch, each of which is a positive sign for the economic well-being of our community members. While the median household income in our community is lower than the state average, our cost of living is also lower. As of January 2025, Rochelle’s cost of living was approximately 35% lower than in Chicago.

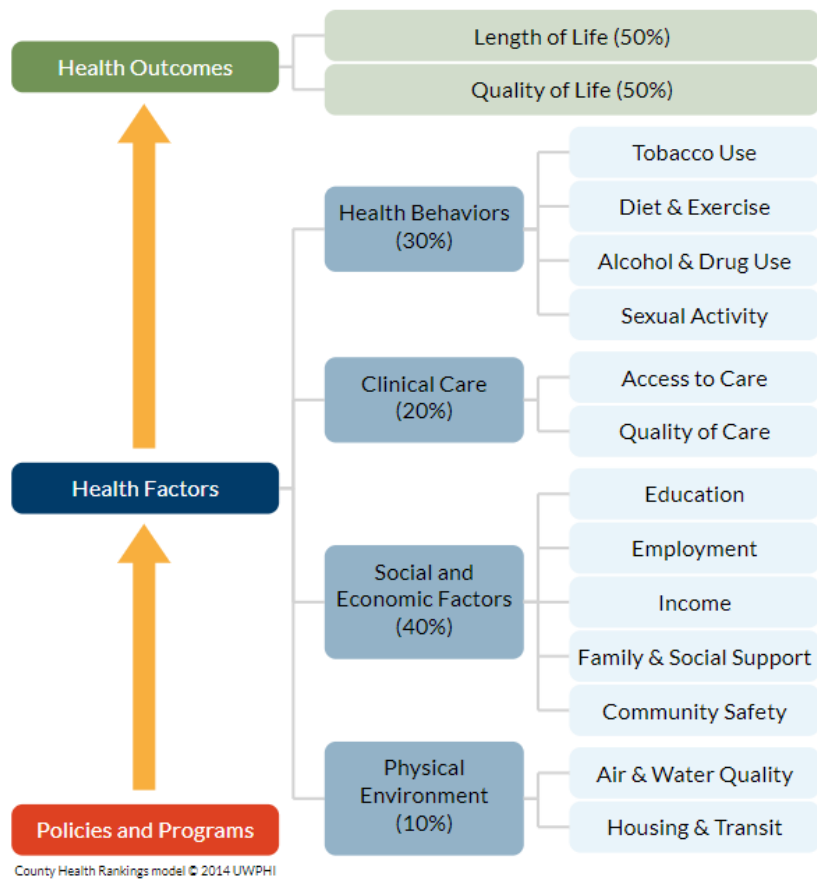
While our community has relatively small minority populations, there is a significant Hispanic community in and around the city of Rochelle, which makes them a high priority in ensuring that Rochelle Community Hospital is effectively addressing their specific health needs. The local Hispanic community consists of a large group of individuals who originally immigrated from Mexico who have lived in the area for a long time, as well as a recent influx of individuals from Cuba. Smaller numbers of individuals are from other countries, like Venezuela and Puerto Rico.

The Population Health Institute (“PHI”) publishes annual health data for every county in the United States. The data is aggregated into *health outcomes* and *health factors*. The PHI separates health outcomes into mortality (length of life) and morbidity (quality of life). Health factors are separated into four factors that largely influence the health outcomes: physical environment, society and economics, clinical care, and health behaviors.

| <b>County Health Rankings (out of 102 Illinois Counties)</b> |                        |                       |
|--------------------------------------------------------------|------------------------|-----------------------|
|                                                              | <b>Ogle<br/>County</b> | <b>Lee<br/>County</b> |
| Mortality (Length of life)                                   | 29                     | 21                    |
| Morbidity (Quality of life)                                  | 23                     | 26                    |
| <b>Overall Health Outcomes</b>                               | <b>22</b>              | <b>21</b>             |
| Health Behaviors                                             | 27                     | 52                    |
| Clinical Care                                                | 46                     | 15                    |
| Social & Economic Factors                                    | 33                     | 46                    |
| Physical Environment                                         | 80                     | 95                    |
| <b>Overall Health Factors</b>                                | <b>32</b>              | <b>47</b>             |

Both counties are among the top quartile of Illinois counties in health outcomes, including quality of life and length of life. However, the health factors rankings are more varied with Lee County having its best ranking in clinical care and Ogle County having its best ranking in health behaviors. Both counties are near the bottom of the rankings in physical environment. The Population Health Institute bases the physical environment rankings on average daily air pollution, drinking water violations per year, percentage of households with at least one of four severe housing problems (overcrowding, high housing costs, lack of kitchen facilities, and lack of plumbing facilities), the percentage of the population that drives alone to work, and the percentage of workers who commute more than 30 minutes to work. Our community does have a lot of individuals who commute alone and who have relatively long commutes, averaging 27 minutes each way. This is

mostly due to the number of individuals in our area who live in one community but work in another.



Source: University of Wisconsin Population Health Institute

Because health outcomes are the long-term results of health factors, the current trends indicate that our community members are currently benefitting from relatively positive choices made in the past but may face worsened future health outcomes as the impact of their current health choices are manifested. However, as the county’s health factor rankings improve, the likely impact on future health outcomes should continue to improve as well.

**Community Health Needs Assessment Methodology**

Rochelle Community Hospital’s executive team led the planning, conducting, and reporting of the community health needs assessment. We contracted with CliftonLarsonAllen LLP, a professional services firm, to gather community input, prepare this Community Health Needs Assessment Report and prepare the Implementation Strategy.

*Interviews*

We gathered qualitative information and perspectives on community health needs through one-on-one and small group interviews with key community stakeholders. These interviews were

conducted in February 2025. The primary goal of these interviews was to obtain a range of perspectives on the community's health needs. We gathered information from the following groups within our community:

- People with special knowledge or expertise in public health
- Government health departments and other government agencies
- Leaders, representatives or members of low-income populations
- Leaders, representatives or members of minority populations
- Leaders, representatives or members of other medically underserved populations, such as adolescents, the elderly and rural individuals

In addition to several members of Rochelle Community Hospital's medical staff and leadership, the following agencies, organizations and businesses participated in the community health needs assessment process by contributing their perspectives, opinions and observations. We thank them for their past and continued assistance.

- Ogle County Health Department
- OSF St. Katharine's Hospital
- Sinnissippi Centers
- Ogle County Focus House
- Rochelle Police Department
- Rochelle School District
- City of Rochelle
- Rock River Center
- Hub City Senior Center
- University of Illinois (Extension)

#### *Quantitative Data*

The community health needs assessment included consideration and analysis of the following publicly available data.

#### Centers for Disease Control and Prevention

- <https://www.cdc.gov/children-mental-health/data-research/index.html>
- <https://www.cdc.gov/nchs/data/databriefs/db508.pdf>

#### City of Rochelle

- <https://www.enjoyrochelle.com/about-rochelle/about-rochelle-illinois.html>

#### Crown Counseling, "Screen Time Statistics: How Much Are We Staring at Screens?"

- [https://crowncounseling.com/statistics/screen-time/#elementor-toc\\_\\_heading-anchor-2](https://crowncounseling.com/statistics/screen-time/#elementor-toc__heading-anchor-2)

#### Economic Research Institute, Cost of Living Data

- <https://www.erieri.com/cost-of-living/united-states/illinois/chicago#:~:text=How%20expensive%20is%20it%20to,affordable%20than%20the%20US%20average.>

Illinois Hospital Association, “City locations of our member hospitals”

- <https://www.team-iha.org/getmedia/03cb2747-50b5-4b8b-869f-0f251f1c088f/iha-member-map-2025.pdf>

Lee County Health Department, 2023 Community Health Needs Assessment

- <https://www.leehealth.org/about-us/community-outreach/community-health-needs-assessment-1>

Mayo Clinic, “Obesity”

- <https://www.mayoclinic.org/diseases-conditions/obesity/symptoms-causes/syc-20375742>

McKinsey & Company, “The Physician Shortage Isn’t Going Anywhere”

- <https://www.mckinsey.com/industries/healthcare/our-insights/the-physician-shortage-isnt-going-anywhere>

National Alliance on Mental Illness

- <https://www.nami.org/wp-content/uploads/2023/07/IllinoisStateFactSheet.pdf>

National Institute on Alcohol Abuse and Alcoholism

- <https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics>
- <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-adverse-impact-health>

Ogle County Health Department, 2020 Illinois Project for Local Assessment of Needs

- [https://www.oglecountyil.gov/departments/health\\_department/iplan.php](https://www.oglecountyil.gov/departments/health_department/iplan.php)

The Population Health Institute and Robert Wood Johnson Foundation, County Health Rankings

- <https://www.countyhealthrankings.org/health-data/illinois/data-and-resources>

Rochelle Community Hospital

- <https://www.rochellehospital.com/>

Rural Health Information Hub, “Health Professional Shortage Areas: Mental Health”

- <https://www.ruralhealthinfo.org/charts/7?state=IL>

Substance Abuse and Mental Health Services Administration

- [https://www.stopalcoholabuse.gov/media/ReportToCongress/2022/state\\_reports/illinois\\_profile.pdf](https://www.stopalcoholabuse.gov/media/ReportToCongress/2022/state_reports/illinois_profile.pdf)

Treatment Magazine, “The Workforce Shortage in Addiction Care Reaches a Crisis Stage”

- <https://treatmentmagazine.com/the-workforce-shortage-in-addiction-care-reaches-a-crisis-stage/>

U.S. Census Bureau QuickFacts

- <https://www.census.gov/quickfacts/fact/table/IL,leecountyillinois,oglecountyillinois/PST045223>

U.S. Chamber of Commerce, “Data Deep Dive: A National Nursing Crisis”

- <https://www.uschamber.com/workforce/nursing-workforce-data-center-a-national-nursing-crisis>

U.S. Department of Health & Human Services

- <https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-summary.pdf>

U.S. Health Resources Services Administration, National Center for Health Workforce Analysis

- <https://bhwa.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf>

### *Information Gaps*

Although we are unable to identify any specific information gaps, we recognize members of the community representing different organizations, groups, etc., have differing opinions concerning community health needs and priorities and may have provided different input if given the opportunity.

### *Analytical Methods Applied*

We applied various analytical methods to the available data. During interviews, we asked participants for their input regarding health needs, the root causes of those needs, the prioritization of those needs, and potential responses to address them. We analyzed the historic prevalence of various health issues in our community and compared those with county, state and national data. Finally, we reviewed previously identified health priorities as identified by national, state and county health organizations.

### *Request for Feedback*

Rochelle Community Hospital was willing to consider written comments related to its last Community Health Needs Assessment Report and Implementation Strategy, but received no such input. If any reader would like to provide input on this community health needs assessment, they can submit their comment(s), in writing, to the following address:

Attention: Administration/CFO  
RE: Community Health Needs Assessment  
900 North 2<sup>nd</sup> Street  
Rochelle, IL 61068

### *Determination of Significance*

While many needs were identified during the community health needs assessment process, this report focuses on those needs that were deemed *significant* by Rochelle Community Hospital. A health need's significance was evaluated based on many factors. The factor given the most weight was the relative importance placed on the health need by community participants. Other factors included the number of people in our community impacted by the health need, the impact of that health need on quality of life and length of life, and the impact on low-income, minority, and other medically underserved populations. The decision was made by Rochelle Community Hospital's leadership team.

### *Process and Criteria for Prioritizing Identified Health Needs*

As with the determination of significance, the prioritization of identified significant health needs was determined based on many factors. The factor given the most weight was the relative importance placed on the health need by community participants. Other factors included the number of people in our community impacted by the health need, the impact of that health need on quality of life and length of life, and the impact on low-income, minority, and other medically



underserved populations. The decision was made by Rochelle Community Hospital's leadership team.

### **Prioritized Community Health Needs**

Based on community input, as well as reviews of hospital, county, state and national health data, Rochelle Community Hospital identified the following significant community health needs:

- Behavioral health, including mental health and substance abuse
- Access to healthcare services
- Obesity and chronic diseases

Access to care, chronic diseases and mental health were each identified as significant community health needs by the Ogle County Health Department in their 2020 community health needs assessment. Similarly, access to healthcare services, mental health, substance abuse, obesity and chronic conditions were identified as significant community health needs by the Lee County Health Department in their 2023 community health needs assessment.

#### *Behavioral Health, Including Mental Health and Substance Abuse*

Mental health among both adults and children was almost unanimously identified as the top concern by community participants, with substance abuse following closely as another major concern.

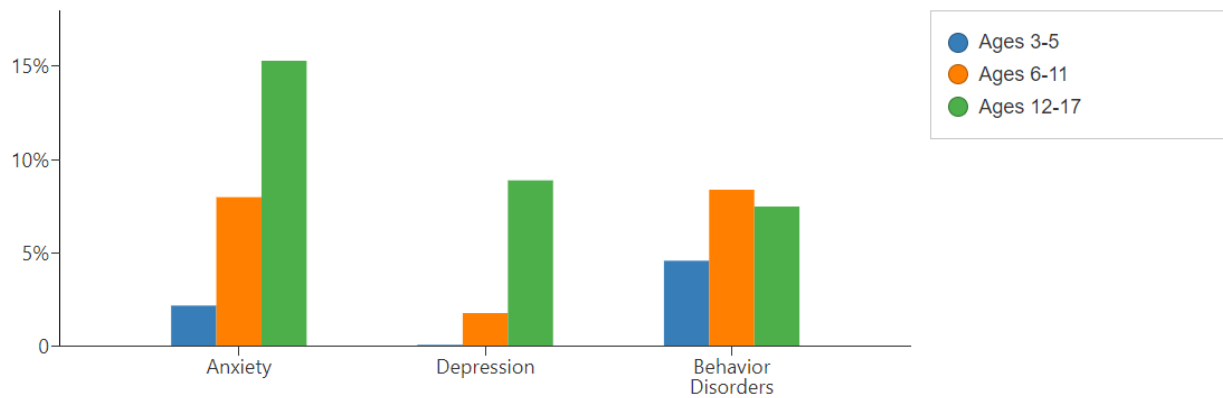
The specific mental health concerns discussed by community participants included:

- **Youth** – impulsive/reactive behaviors, depression, and anxiety stemming from neglect, all types of abuse, family financial struggles, bullying at school and online, puberty/physical development, shaming, lack of “safe places”, body dysmorphia, gender dysmorphia, and multigenerational trauma, as well as ADHD
- **Adults** – depression and anxiety stemming from financial stress, spousal abuse, and post-traumatic stress syndrome (PTSD)
- **Elderly** – the same concerns as other adults, but adding dementia and memory loss

Although each of these issues have been a concern in our community for a long time, community participants agreed that each issue worsened during the COVID pandemic. Community participants primarily expressed concerns related to the prevalence of mental health issues in the area, a continuing stigma about admitting an individual may have a mental health concern, and the availability of health care services when a mental health issue arises.

According to the Centers for Disease Control and Prevention (“CDC”), one in seven U.S. children had a current diagnosed mental or behavioral health condition in 2018-2019. With limited exceptions, the prevalence of anxiety, depression and behavior disorders increase as a child approaches adulthood.

## Mental and Behavioral Health Conditions by Age



The same CDC report provides the following about U.S. high school students in 2023:

- 40% reported persistent feelings of sadness or hopelessness in the past year.
- 20% reported seriously considering suicide in the past year.
- 9% reported attempting suicide in the past year.

According to the U.S. Department of Health & Human Services, the prevalence is even higher among low-income youth (21%), youth in the child welfare system (50%) and youth in the juvenile justice system (70%). Additionally, an estimated 49.5% of adolescents have had a mental health disorder at some point in their lives. Among children ages 3-17, 9.8% were diagnosed with ADHD, 9.4% were diagnosed with anxiety, 4.4% were diagnosed with depression, 2.9% were diagnosed with eating disorders, and 8.9% were diagnosed with various other behavior problems.

The general consensus among community participants is that adolescent mental health problems became much more common and more severe during the COVID pandemic and that these problems are exacerbated by social media. This appears to be supported by statistics from the National Alliance on Mental Illness, which reports that in 2021:

- More than half of Americans report that COVID-19 had a negative impact on their mental health.
- One in six U.S. youth aged 6-17 experience a mental health disorder each year.
- 38.5% of adults in Illinois reported symptoms of anxiety or depression.
- 28% of those reported that they were unable to receive needed counseling or therapy.
- Of those who did not receive mental health care, 33.2% reported that the cause was cost.
- 38% of people in Illinois live in a community that does not have enough mental health professionals, mostly in the rural areas of the state.
- 61.8% of Illinoisans age 12-17 who have depression did not receive any care in the last year.
- Illinoisans are three times more likely to be forced “out of network” for mental health care than they are for primary health care, making it more difficult to find care and less affordable due to higher out-of-pocket costs.

Social media is a significant enough concern that in early 2024 the U.S. Surgeon General recommended added a warning label to all social media platforms. From their report,

“Social media can provide benefits for some children,... However, increasingly, Evidence is indicating there is reason to be concerned about the risk of harm social media use poses to children and adolescents. Children and adolescents on social media are commonly exposed to extreme, inappropriate, and harmful content, and those who spend more than 3 hours a day on social media face double the risk of poor mental health including experiencing symptoms of depression and anxiety. This is deeply concerning as a recent survey of teenagers showed that, on average, they spend 3.5 hours a day on social media.”

The Surgeon General based that conclusion on the following statistics:

- Approximately 40% of children aged 8-12 and 95% of teenagers used social media in 2022.
- When asked about the impact of social media on their body image, 46% of adolescents aged 13-17 said social media makes them feel worse, 40% said it makes them feel neither better nor worse, and only 14% said it makes them feel better.
- Roughly two-thirds of adolescents are “sometimes” or “often” exposed to hate-based content.
- Research indicates that social media may perpetuate body dissatisfaction, disordered eating behaviors, social comparison and low self-esteem, especially among adolescent girls.

Community participants raised concerns about a stigma in the community related to mental health issues. Individuals seem more willing to admit to and discuss physical ailments than mental illnesses, whether it be their own issue or a family member or friend's. This appears to be less of a concern among adolescents and young adults but more of a barrier in the more rural communities, more conservative communities and in the Hispanic community. However, community participants expressed hope that the situation is naturally improving as more and more of the population accepts mental health as a common, reasonable area needing care.

Substance abuse covers a broad range of health issues, including tobacco, alcohol, prescription drugs, and illicit drugs. Each of these is a health need in our state and community, although alcohol, opioids, heroin, fentanyl, marijuana/THC and underage vaping are currently considered the most significant by interview participants.

Community participants expressed significant concerns about alcohol use in our area. According to the National Institute on Alcohol Abuse and Alcoholism, alcohol is the most commonly abused substance in the United States. In a 2023 survey:

- 84.9% of adults reported drinking alcohol at some point in their lifetime and 51.6% reported that they drank alcohol in the last month.
- 21.6% of youth ages 12-17 reported drinking alcohol at some point in their lifetime and 6.9% reported drinking alcohol in the last month.
- 23.5% of adults reported that they engaged in binge drinking within the last month.

- 3.9% of youth ages 12-17 reported that they engaged in binge drinking within the last month.
- 2.9% of youth between the ages of 12 and 17 had alcohol use disorder, a chronic brain disorder marked by compulsive drinking, loss of control over alcohol use, and negative emotions when not drinking. AUD in this age-group was more common among girls than boys.

The majority of these statistics are slightly improved compared to the 2020 survey, except for teenage binge drinking, which worsened from 1.7% to 3.9%.

According to the Population Health Institute, approximately one out of every seven adults – 17.5% of adults in Illinois and 17.3% of adults in our community – indicated that they drank excessively in 2023. Additionally, 38.8% of driving deaths in our community involved alcohol impairment, which was well above the state’s rate of 27.9%. Further, this problem isn’t limited to adults. In a 2022 survey conducted by the Substance Abuse and Mental Health Services Administration, alcohol consumption within the last month in Illinois increased from 2.6% in Middle School to 16.8% in high school, then 62.8% in adults over age 21.

## Illinois

**State Population: 12,587,530**

**Population Ages 12–20: 1,506,000**

| Past-Month Alcohol Use                             |                   |
|----------------------------------------------------|-------------------|
| <b>Ages 12–20</b>                                  |                   |
| Past-Month Alcohol Use – Number (Percentage)       | 288,000 (19.1%)   |
| Past-Month Binge Alcohol Use – Number (Percentage) | 171,000 (11.3%)   |
| <b>Ages 12–14</b>                                  |                   |
| Past-Month Alcohol Use – Number (Percentage)       | 12,000 (2.6%)     |
| Past-Month Binge Alcohol Use – Number (Percentage) | 2,000 (0.5%)      |
| <b>Ages 15–17</b>                                  |                   |
| Past-Month Alcohol Use – Number (Percentage)       | 89,000 (16.8%)    |
| Past-Month Binge Alcohol Use – Number (Percentage) | 47,000 (8.9%)     |
| <b>Ages 18–20</b>                                  |                   |
| Past-Month Alcohol Use – Number (Percentage)       | 187,000 (35.9%)   |
| Past-Month Binge Alcohol Use – Number (Percentage) | 121,000 (23.3%)   |
| <b>Adults Ages 21+</b>                             |                   |
| Past-Month Alcohol Use – (Percentage)              | 5,750,000 (62.8%) |
| Past-Month Binge Alcohol Use – (Percentage)        | 2,728,000 (29.8%) |

Alcohol abuse is a significant concern because of its commonality and the major impacts it has on our community. According to the National Institute on Alcohol Abuse and Alcoholism:

- An estimated 178,000 deaths are attributable to excessive alcohol use, making it one of the leading preventable causes of death in the United States, behind tobacco, poor diet, physical inactivity, and illegal drugs.
- Alcohol misuse costs the United States approximately \$249 billion per year.

Community participants indicated that they are concerned about local use of opioids such as fentanyl, heroin, and prescription medicines. Heroin abuse sometimes arises from the initial use and abuse of other opiates, also known as prescription pain killers. Commonly abused opiates include codeine, morphine, oxycodone, methadone, hydromorphone, hydrocodone and fentanyl. Heroin can cause damage to various organs, including the heart, lungs, liver and kidneys. It can also cause breathing problems, collapsed veins, and poses special problems related to the transmission of HIV, Hepatitis C, and other diseases that can occur with sharing needles. The resurgence of opiate-related problems in the United States has increased emergency room visits, crime, homicides, high school drop-outs, and loss of employment across the nation.

Finally, community participants expressed concern over the significant rise of vaping in our communities' schools, including marijuana and THC products. Participants indicated that vaping is increasingly common among adolescents but that community parents are either not aware or are unwilling to admit just how common it has become. Based on a national study conducted in 2021, Illinois ranks 8<sup>th</sup> in the country with 19.9% of high school students actively using vaping products. By comparison, Illinois ranks 2<sup>nd</sup> in the country in adult vaping, at only 2.4%, which emphasizes the different perspectives on vaping between adults and adolescents across the state.

Participants expressed concern over the connection between substance abuse and mental health, with one participant estimating that 90% of those struggling with substance abuse also have mental health problems, emphasizing the impact each can have on the other as well as the importance of treating both problems simultaneously for effective recovery. While our proximity to Chicago provides access to a broad array of emergency and short-term acute care services, our community needs a stronger stepdown program and a long-term recovery system that would typically assist with job coaching, vocational training, housing, food, transportation, and social interaction for those in recovery. This is a particularly strong concern because our community is able to assist many individuals through short-term acute (severe) mental health and substance abuse problems but frequently lacks sufficient resources to help those individuals through the months-long or years-long process of fighting those same problems to achieve a healthy life.

Medical professionals expressed a need for additional outreach from the mental health and substance abuse professionals in our community to other medical professionals to encourage cooperative planning and treatment for individuals with multiple health problems ("co-morbidities"). Similarly, medical professionals indicated a need for better "dual diagnosis" treatment programs within the community to simultaneously treat both mental health and substance abuse problems. Because of the close connection between mental health and substance abuse, any treatment of one is more likely to fail if the other is not also treated effectively.

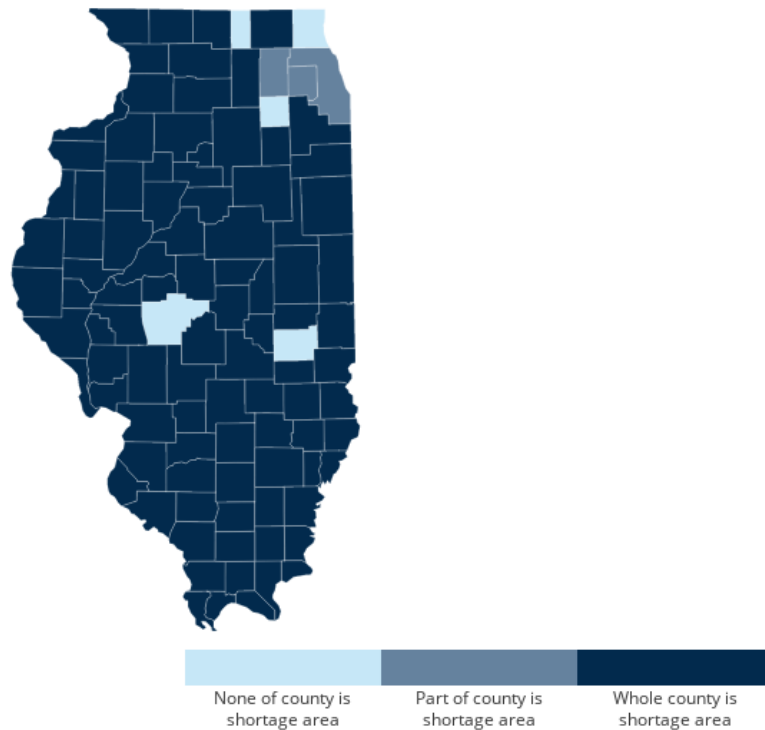
#### *Access to Care*

Many of our community participants' behavioral health concerns relate closely to access issues. Rochelle Community Hospital does not currently have a focused mental health treatment department, although OSF – St. Katharine's Hospital in Dixon does have a behavioral health treatment department. Additionally, the county health departments, Sinnissippi Centers and other local organizations and providers provide behavioral health services to community. See the end of this report for a list of currently available resources in these areas. Despite the effort currently

being expended to help the community, participants perceived a need for additional counselors with less frequent turnover, a need for more facilities across the continuum of care, and a lack of consistent follow-up and outpatient care that would lead to long-term changes in a person's health.

Unfortunately, attracting providers is difficult given our rural environment. The map provided below from the Rural Health Information Hub shows that most of the state of Illinois is facing a mental health professional shortage. Note that the lighter blue area in the northeastern corner of the state, with more mental health providers, is the greater Chicago Metropolitan area.

**Health Professional Shortage Areas: Mental Health, by County, October 2024 - Illinois**



Source: [data.HRSA.gov](https://data.HRSA.gov), October 2024.

Dedicating more resources to mental health services would require recruiting more staff with the appropriate credentials, but there is a shortage of mental health providers across the state and nation. The current workforce of mental health providers is aging out of the profession or are burning out and leaving the field and these factors are outpacing the number of incoming mental health professionals. Combining this declining overall number of providers with increasing consumer demand, the consensus is that this service is likely to remain a major health problem within our community and the nation in the foreseeable future. In December 2023, the National Center for Health Workforce Analysis issued a report on the shortage of behavioral health care providers in the United States. From that report,

“The United States is experiencing a mental health crisis with increased levels of unmet behavioral health needs among people of all ages. The capacity of the behavioral health

workforce to meet the demand is limited by supply and distribution challenges. However, the challenges facing the behavioral workforce extend beyond the supply and demand issues and include:

- Patient-level barriers, such as stigma and ability to pay that both hinder access to care
- Provider-level barriers, such as limited scopes of practice, reimbursement challenges, and clinician burnout all of which limit the ability to provide high-quality care.”

Similar to mental health, community participants expressed concerns about access to health care treatment services for substance abuse. The two greatest needs expressed by community participants were for additional inpatient and transitional care facilities, although the availability of care depends largely on a person’s financial situation and ability to travel great distances for care. Insurance companies have various positions on whether substance abuse treatment is eligible for coverage and, if so, which facilities may be used. In addition, some insurance providers will not cover services provided by specific types of doctors, nurses and specialists even though those providers may be best able to treat an individual’s needs. Clearly, this is one area of medicine in desperate need of reform at the state and national levels.

Unfortunately, attracting substance abuse treatment providers is also difficult given our rural environment. According to a November 2021 article from Treatment Magazine,

“Skilled behavioral healthcare workers have historically been hard to find, not to mention retain. The work isn’t easy and is accompanied by high burnout rates, especially in the addiction treatment field. Layer on a once-in-a-century pandemic, and suddenly the addiction treatment field in the U.S. is faced with an unprecedented workforce shortage.

“Back in 2015, Pew Charitable Trusts spotlighted the problem in a first-of-its-kind ‘provider availability index’ that showed how many behavioral health professionals—psychiatrists, counselors and social workers—were available in each state to treat the estimated 20 million people across the country with a substance use disorder (SUD). The numbers ranged from a high of 70 providers for every 1,000 adults with addiction in Vermont to a low of 11 per 1,000 in Nevada. Nationally, according to Pew, the average at the time was 32 behavioral health specialists for every 1,000 people with SUD. The report did not determine an ideal ratio but noted widespread consensus that the workforce was inadequate. One addiction expert in the report called the crisis “severe.”

The article further discusses the impact of the COVID pandemic on treatment services:

“In many places, it’s only gotten worse since then....

In a special September 2021 Psychiatry Online report, researchers contended that a ‘rapid and substantial’ scaling up of access to effective treatment is needed to address the opioid crisis, which approached 100,000 overdose deaths in the latest

12-month period measured by the Centers for Disease Control and Prevention (CDC). ‘Strategies to increase access are hindered by a lack of treatment providers,’ the paper’s authors say...”

Finally, the article discusses the special challenges faced by rural providers.

“Many residential treatment centers are located on isolated rural campuses far from urban areas. Recruiting staff to work at these facilities is more difficult—the locale may not be desirable for potential workers who might be weighing the availability of resources such as schools, transportation, shopping, and cultural and recreational opportunities. Additionally, Ventrell notes, the treatment field has slowly evolved from a social model (like the 12 steps) to a medical model in which it is essential to provide medical care. Concentrations such as psychiatry are often not the first choice in medical schools, he says. Add to that the notion that addiction is one of the least understood areas of behavioral health, and the hiring pool becomes even more limited.”

Aside from behavioral health, access to health care services in general was also frequently identified as one of the most significant health needs in our community. Aside from behavioral health issues, concerns related to access to care can generally be classified into the following areas: transportation issues, inappropriate use of the Emergency Room (“E.R.”), insufficient local specialty services, the needs of the low-income community, access to services outside of normal work hours, and special needs for the Hispanic community.

While participants indicated appreciation for the local hospitals, medical clinics and medical providers, they frequently identified community members’ difficulty in physically getting to those locations as a major concern across the area, for multiple reasons. First, participants are concerned about the availability of transportation across the community. Some individuals don’t have and/or can’t afford a working vehicle capable of driving to the necessary healthcare facility. Similarly, others – youth under 16, some elderly individuals, those with physical disabilities – aren’t able to drive themselves even if they have access to a vehicle. Second, those who can’t drive themselves to a healthcare facility may not have family or friends who could drive them. Third, our area has a very limited public transportation system, with those options offering limited times, limited geographic service areas, and/or limited allowed users. Fourth, even for those individuals who have transportation, each healthcare visit requires a significant amount of time, which means time away from work, school and other daily demands. Finally, the winter weather – snow, ice, etc. – can create additional challenges for individuals.

While community members generally expressed praise regarding the E.R. facilities in the area they expressed concern over the community’s use of the E.R. First, community participants believe that individuals are delaying or avoiding preventive care to the point that an easily treated condition develops into a more severe issue that requires a trip to the E.R. The causes for such avoidance could include cost, time, lack of personal accountability, ignorance regarding the issue, or a distrust of the medical providers. Whatever the cause, such avoidance results in more intensive care that takes more time and is more costly once it develops into an emergency situation. Although the



E.R. is the appropriate place for such emergencies, they could be avoided altogether with more preventive measures initiated by community members. Second, community participants believe that individuals facing acute mental health and substance abuse crises frequently end up in the E.R. to address their condition, with a relatively small number of individuals requiring a fairly large amount of time and effort to care for.

Community members often identified a lack of local specialty services as a community need. Rochelle Community Hospital has only a handful of full-time specialist medical providers, with the remaining specialty services being offered on a part-time basis through contracts with other area hospitals and medical groups. Desired local specialty services identified by participants include OB/GYN, cancer treatment, dialysis, neurology, pulmonology, infectious disease, and pain specialists. These types of services may require traveling greater distances to larger hospitals in Rockford, DeKalb or Chicago, which could be up to a 2-hour drive away.

Low-income community members may have additional struggles in receiving effective and thorough health care. As costs have risen, this challenge has expanded into the middle class who do not qualify for government benefits and typically have high deductible health plans. Those who are uninsured or underinsured and low-income may not be able to receive regular preventive care, meaning small health problems may develop into major health problems. Low-income community members face all the same health risks – obesity, mental health issues, substance abuse, heart disease, diabetes, etc. – as other community members, but low-income individuals have fewer alternatives to receive treatment to meet those needs.

Interview participants expressed concern about the hours during which health care services and prescriptions can be obtained. Emergency services are available at all times and on all days. However, as individuals work longer hours and/or multiple jobs, it becomes increasingly difficult to leave work during weekdays to go to medical appointments or to fill prescriptions. That concern is magnified for lower-income, elderly, young and disabled individuals who may rely on others for transportation and, therefore, can not completely control when and how quickly they travel, as well as for more rural individuals.

Finally, the local Hispanic community faces the additional barrier of having limited English proficiency. Rochelle Community Hospital utilizes several employees who speak Spanish as a second language for interpretive services but relies mostly on interpretive software to assist in serving these individuals. While the interpretive software is readily available 24 hours per day and is capable of interpreting thousands of languages and dialects, medical information can be difficult to communicate even in your native language and it's important that the details be communicated accurately, so we acknowledge the need to continue to focus on providing the most effective interpretive services to the Hispanic community and others in the area who have limited English proficiency.

#### *Obesity and Chronic Diseases*

Like the rest of the country, our community members frequently identified obesity as a health concern, related to both healthy eating and healthy living, as well as the attendant chronic diseases that may arise from it.

As of August 2023, 40.3% of adults in the United States were obese and 9.4% of adults were severely obese, with both prevalences being slightly higher in women than in men. Illinois and our community are healthier, with 34.3% of Illinois adults being obese and 35.9% of adults in our community being obese. However, that still means more than one in three adults in our community are classified as obese.

Participants believe that obesity in our community is the result of multiple issues including difficulty accessing healthy foods, being able to turn those healthy foods into a meal that people willingly eat, unhealthy living habits, and a general mass complacency that obesity is just normal now.

The first obstacle to healthy eating in our community is being able to obtain healthy foods. While Rochelle and Dixon have major national grocery chains like Walmart and Aldi, many of our smaller towns and communities have more limited options for grocery shopping, like smaller grocery stores, convenience stores, gas stations, or no local grocery options at all. These smaller stores naturally have fewer options for the types of foods to purchase. Therefore, individuals in more rural areas or who have difficulty with transportation face greater barriers in getting to the store to buy groceries. The second obstacle to healthy eating is being able to afford healthier foods like proteins, fruits and vegetables. Community participants expressed appreciation that our stores, including Walmart, Aldi, SuperValu and Dollar General, seem to provide foods at more reasonable prices while also acknowledging that healthier whole foods tend to be more expensive than heavily processed (i.e. boxed, canned or frozen) foods. Similarly, interview participants indicated that the majority of meals available in local restaurants seem to be of less healthy nature. The third obstacle to healthy eating is the food preparer having knowledge of how to turn healthy raw ingredients into a meal that they and their families will eat, as well as the time to prepare such a meal. Again, as individuals spend more time on other tasks – working longer hours, working more jobs, spending more time on social media and other online activities, etc. – they have less time available for other daily tasks, such as preparing a home-cooked meal. Finally, as these home-cooked meals become less frequent, preparers lose knowledge practice while family members simultaneously become less comfortable with those healthier meals.

Interview participants indicated that unhealthy living habits in our community stem from a lack of consistent daily activity, a natural movement towards sedentary jobs and technology-based activities and insufficient use of locally available exercise options, each of which is exacerbated by challenging winter weather for a large portion of the year.

According to a 2025 report, “screen time” statistics in the United States were as follows in 2023:

- Adults spent an average of 7 hours, 3 minutes on screens daily, which was 23 minutes higher than the global average and 33 minutes higher than the 2017 average.
- Gen Z (i.e., individuals born between 1997 and 2012) spent an average of 9 hours on screens daily.
- Millennials (i.e., individuals born between 1981 and 1996) spent an average of 6 hours, 42 minutes on screens daily.
- 53% of children aged 8-12 owned smartphones.

While interview participants feel our community may be slightly better than the national averages, they feel the overall trends of increased screen time and decreased physical activity are accurate for our community.

Interview participants also expressed concerns regarding our community's use of available exercise options. Larger communities like Rochelle and Dixon have more gyms, parks, recreational leagues and school-based exercise opportunities. Those options decrease significantly in smaller communities. However, even in the larger communities, participants indicated that the community doesn't appropriately utilize the available resources. It's unclear why that's the case, with possible explanations including cost, time and apathy.

Obesity is a major concern across the United States because of the related health issues that it can cause. According to the Mayo Clinic, people with obesity are more likely to develop a number of potentially serious health problems, including:

- Heart disease and strokes: obesity makes you more likely to have high blood pressure and abnormal cholesterol levels, which are risk factors for heart disease and strokes.
- Type 2 diabetes: obesity can affect the way the body uses insulin to control blood sugar levels, which raises the risk of insulin resistance and diabetes.
- Certain cancers: obesity may increase the risk of cancer of the uterus, cervix, endometrium, ovary, breast, colon, rectum, esophagus, liver, gallbladder, pancreas, kidney and prostate.
- Digestive problems: obesity increases the likelihood of developing heartburn, gallbladder disease and liver problems.
- Sleep apnea: people with obesity are more likely to have sleep apnea, a potentially serious disorder in which breathing repeatedly stops and starts during sleep. \
- Osteoarthritis: obesity increases the stress placed on weight-bearing joints, in addition to promoting inflammation within the body, which may lead to complications such as osteoarthritis.

## **Conclusion**

Rochelle Community Hospital conducted this community health needs assessment to better understand our community and the individuals we serve. The hospital is currently developing a strategy to respond to its significant community health needs and will create an Implementation Strategy to formalize those responses. That Implementation Strategy will be approved by the board of directors no later than October 15, 2025, and will be used by the organization as a guide for thoughtful, impactful decisions and actions in the coming years.

## **Health Resources**

The following pages include a list of resources currently available in our community to address the significant community health needs discussed in this report. Despite our efforts, we recognize that this list may not be all-inclusive and welcome any information to add available resources and increase its usefulness. Such information can be sent to the address provided on page 8 of this report.

The Ogle County Health Department and Lee County Health Departments provide support to our community members in numerous ways. The services and programs offered by the Ogle County Health Department include:

- Environmental health (food, well/septic, vector, etc.)
- Clinical services
  - Communicable diseases
  - Immunizations
  - Sexually transmitted diseases
  - Rabies
- WIC and family case management
- Public health emergency preparedness
- Food and nutrition
- Other community programs (medical cannabis, Narcan and tobacco)

The services and programs offered by the Lee County Health Department include:

- Maternal and child services
- Community and personal services
- Environmental health
- Emergency preparedness and response

For a complete list of their activities and related resources, we recommend visiting their offices and/or websites:

- Ogle County Health Department  
907 Pines Road, Oregon  
(701) 852-1376  
[www.oglecountyil.gov/departments/health\\_department/](http://www.oglecountyil.gov/departments/health_department/)
- Ogle County Health Department Branch Office (Se habla Espanol)  
501 Lincoln Highway, Rochelle  
(815) 562-6976  
[www.oglecountyil.gov/departments/health\\_department/](http://www.oglecountyil.gov/departments/health_department/)
- Lee County Health Department  
309 S Galena Avenue, Suite 100, Dixon  
(815) 284-3371  
[www.lchd.com](http://www.lchd.com)

In addition to governmental support, the following facilities are currently available in Ogle and Lee Counties. Many other services are available just outside the borders of this area, especially in Rockford to the north, Rock Falls and Sterling to the west. DeKalb to the east, and Mendota to the south.

#### *Hospitals*

- Rochelle Community Hospital – 900 N 2<sup>nd</sup> Street, Rochelle
- OSF St. Katharine's Hospital – 403 E 1<sup>st</sup> Street, Dixon

#### *Medical Clinics and Specialty Practices*

- Rochelle Community Hospital Family Healthcare Clinic – 900 N 2<sup>nd</sup> Street, Suite 200, Rochelle (on the 2<sup>nd</sup> floor of the Health & Wellness Center)
- Xcel Orthopedics Clinic, Rochelle Community Hospital – 900 N 2<sup>nd</sup> Street, Rochelle
- Xcel Orthopedics Clinic, Rochelle Community Hospital – 2670 DeKalb Ave, Sycamore
- Rochelle Community Hospital Convenient Care Clinic – 900 N 2<sup>nd</sup> Street, Rochelle
- Rochelle Community Hospital Occupational Health Clinic – 900 Petro Road, Rochelle
- Dr. Basith M. Osmani, MD – 1219 Currency Court, Rochelle
- Swedish American Medical Group – 380 IL-38 E, Rochelle
- CGH Dixon Medical Center – 1321 N Galena Avenue, Dixon
- ILCC – 101 W 2<sup>nd</sup> Street, Dixon
- OSF St. Katharine – Center for Health – 102 S Hennepin Avenue, Dixon
- OSF St. Katharine – Center for Health – 215 E 1<sup>st</sup> Street, #214, Dixon
- Physicians Immediate Care – 1672 S Galena Avenue, Dixon
- MercyHealth Byron – 130 Kysor Drive, Byron
- OSF Medical Group – Primary Care – 109 N Franklin Street, Byron
- UW Health Byron Clinic – 230 W Blackhawk Drive, Byron
- KSB Center for Health Services – 1307 W Washington Street, Suite 145, Oregon
- CGH Polo Medical Center – 711 S Division Avenue, Polo
- KSB Center for Health Services – 1107 S Division Avenue, Polo
- UW Health Davis Junction Clinic – 5665 N Junction Way, Davis Junction
- KSB Ashton Family Health Center – 320 N 1<sup>st</sup> Street, Ashton
- OSF St. Katharine – Center for Health – 305 Joe Drive, Amboy

#### *Pharmacies and Medical Supplies*

- Rochelle Pharmacy – 314 Lincoln Highway, Rochelle
- Walgreens Pharmacy – 1080 N 7<sup>th</sup> Street, Rochelle
- Walmart Pharmacy – 311 IL-38, Rochelle
- Genoa Healthcare – 325 IL-2, Room 23, Dixon
- Northern Illinois Home Medical Supply – 1309 N Galena Avenue, Dixon
- Walgreens Pharmacy – 1275 N Galena Avenue, Dixon
- Walmart Pharmacy – 1640 S Galena Avenue, Dixon
- Snyders Pharmacy – 100 W Blackhawk Drive, Byron
- Oregon Healthcare Pharmacy Services – 1100 Pines Road, Oregon

- Snyders Pharmacy – 201 N 4<sup>th</sup> Street, Oregon
- Polo Pharmacy – 111 E Mason Street, Polo
- Mt. Morris Pharmacy – 117 S Wesley Avenue, Mt. Morris
- Amboy Hometown Pharmacy – 221 E Main Street, Amboy

*Mental Health and Chemical Dependency Services*

- Braden Counseling Center – 951 S 7<sup>th</sup> Street, Rochelle
- Changes Counseling – 604 N Main Street, Rochelle
- Jennifer Hay – 555 Fairview Drive, Rochelle
- Sinnissippi Centers – 1321 N 7<sup>th</sup> Street, Rochelle
- Adult Education Associates – 748 Timber Creek Road, Dixon
- H&N Counseling – 404 N Galena Avenue, Suite 50, Dixon
- Living Well Counseling – 116 E 1<sup>st</sup> Street, Dixon
- Melissa A. Gates, LCSW – 404 N Galena Avenue, #240, Dixon
- Mobre Counseling Services – 119 W 1<sup>st</sup> Street, #110, Dixon
- OSF St. Katharine – Behavioral Health – 403 E 1<sup>st</sup> Street, Dixon
- Rays of Wellness – 1254 N Galena Avenue, Dixon
- Reflect Counseling Services – 923 S Peoria Avenue, Dixon
- Reuter Counseling – 1254 N Galena Avenue, Suite B, Dixon
- Roberts Counseling – 114 E Everett Street, Suite 209, Dixon
- Sinnissippi Centers – 325 IL-2, Dixon
- Braden Counseling Center – 300 W Washington Street, #203, Oregon
- Path to Healing – 134 E Blackhawk Drive, Byron
- Rockford Sexual Assault Counseling – 412 W Washington Street, Oregon
- Sinnissippi Centers – 100 Jefferson Street, Oregon
- Kreider Services – 317 W Division Street, Amboy

# Rochelle Community Hospital

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Focus Group Findings, Key Stakeholder Interviews, and  
Secondary Data Analysis

April 2022



525 South Lee Avenue, Suite 320

Duluth, Minnesota 55802

(218) 727-9390 | [info@ruralcenter.org](mailto:info@ruralcenter.org) | [www.ruralcenter.org](http://www.ruralcenter.org)

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# Introduction

Rochelle Community Hospital (RCH) is a 25-bed critical access hospital (CAH) located in Rochelle, Illinois, within Ogle County. RCH participated in Community Health Needs Assessment (CHNA) services administrated by Rural Health Innovations (RHI), a subsidiary of the National Rural Health Resource Center. In September 2021, The Center conferred with leaders from RCH to discuss the objectives of a regional CHNA.



A secondary data analysis, a series of focus groups, and key stakeholder interviews were conducted. Methodology and findings of the focus groups, key stakeholder interviews, and secondary data are discussed later in the report.

**Report findings may be used for:**

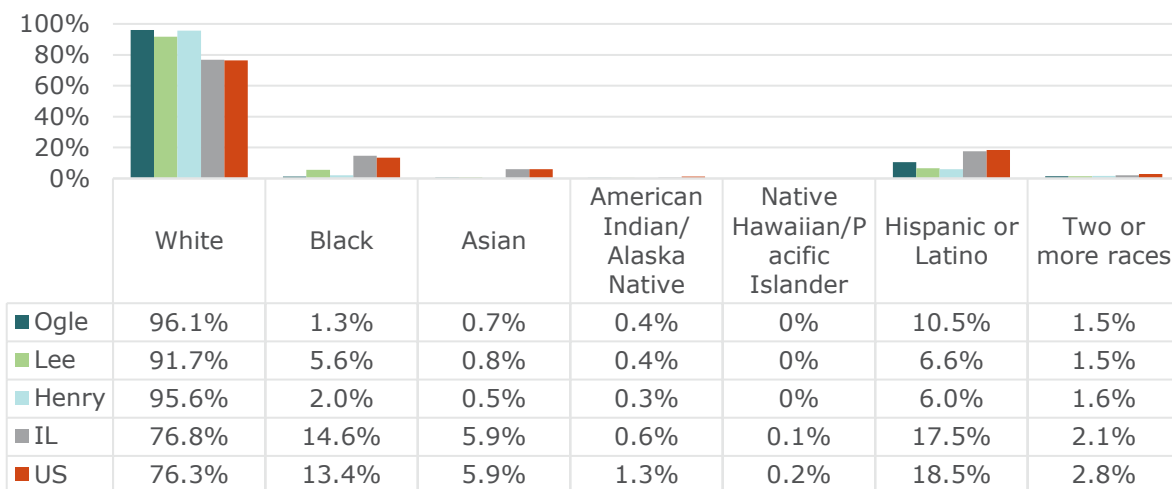
- Developing and implementing plans to address key issues as required by the Patient Protection and Affordable Care Act §9007 for 501(c)3 charitable hospitals
- Promoting collaboration and partnerships within the community or region
- Supporting community-based strategic planning
- Writing grants to support the community’s engagement with local health care services
- Educating groups about emerging issues and community priorities
- Supporting community advocacy or policy development

| Secondary Data                                                                      | Perception of Community Health                                                      | Utilization and Perception of Local Health Services                                   |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
|  |  |  |

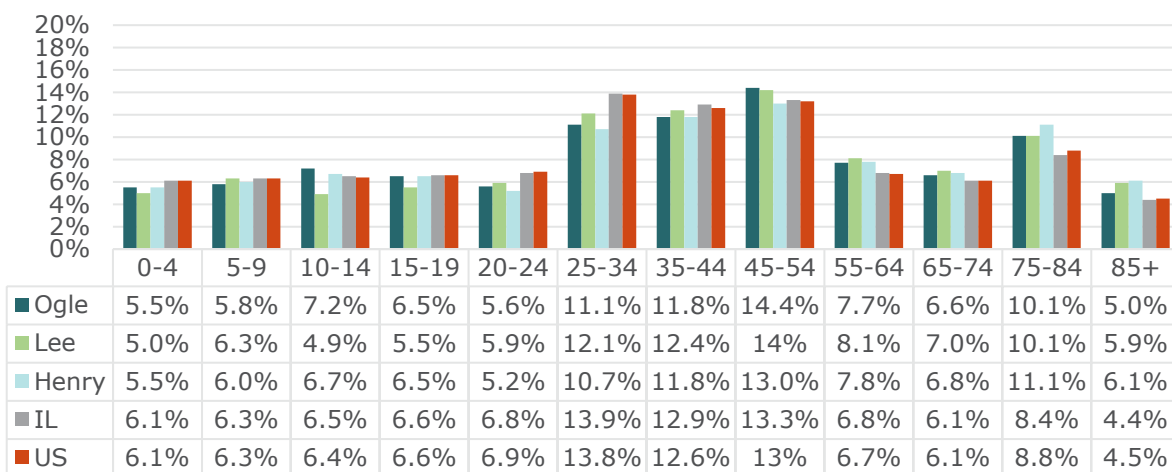
# Demographics

The population in the three counties is largely White. In Ogle County, there is a notable Hispanic or Latino population of 10.5%. The 45-54 age range has the highest percentage of residents and is slightly higher than IL and US for Ogle and Lee counties. This is followed by the 35-44 age range. The number of residents in the 75-84 and 85+ age ranges are higher than IL and US. The number of residents in the 25-34 age range are lower than for IL and US.

**POPULATION BY RACE AND ETHNICITY**

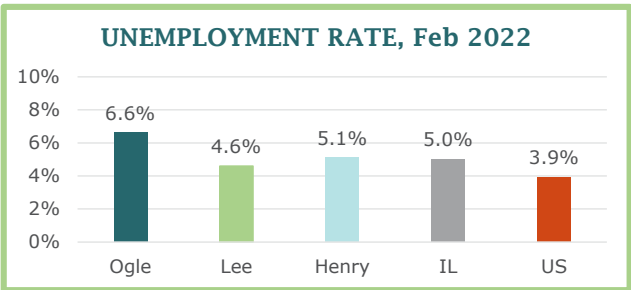
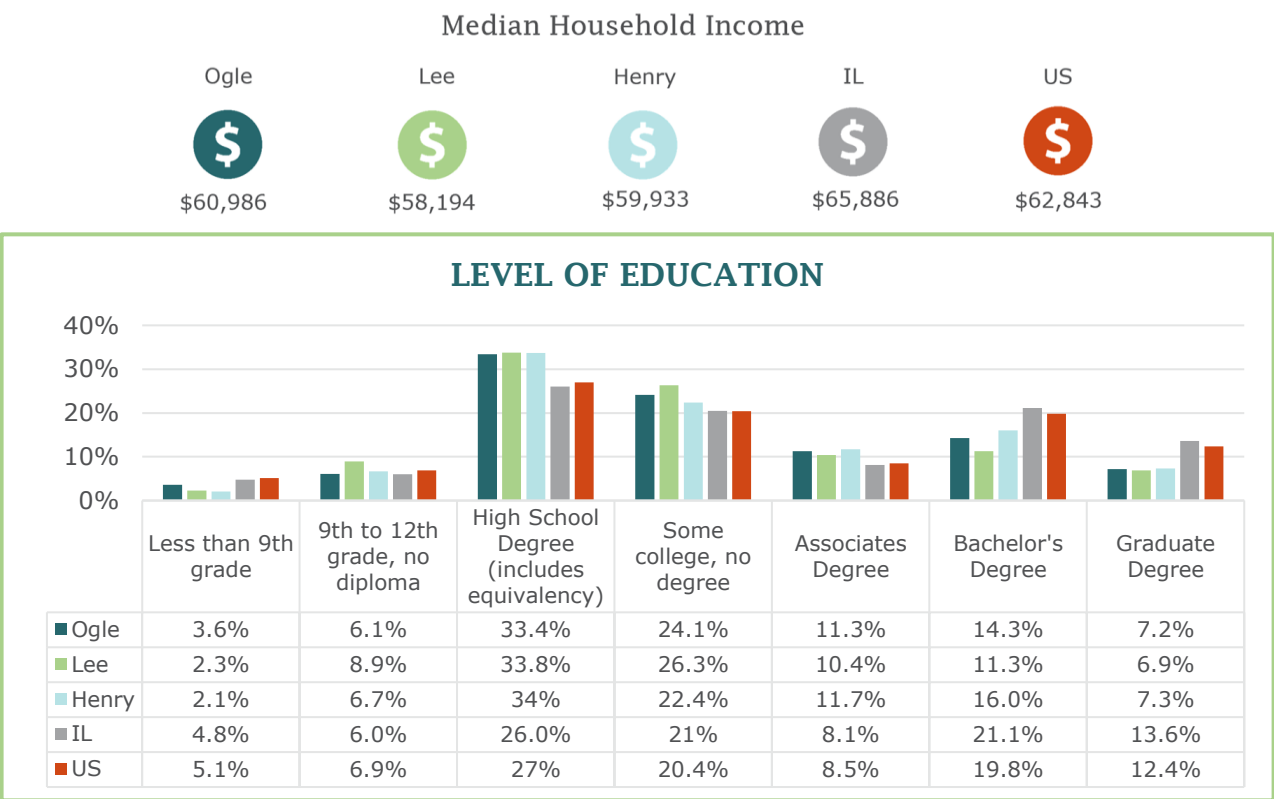


**POPULATION BY AGE**



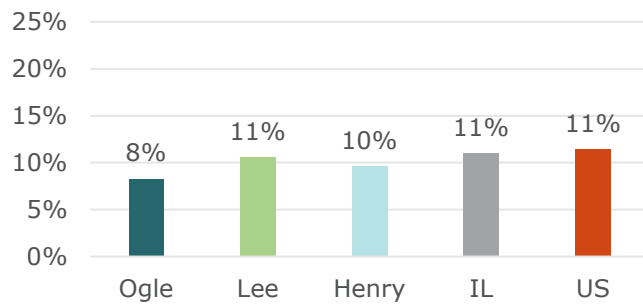
# Social and Economic Factors

The median income for the three counties is lower than IL and US. The unemployment rate in Ogle County is higher than the other counties, IL, and US. Ogle County (8%) has a lower percentage of residents living below the poverty level while Lee (11%) and Henry (10%) are comparable to the state and US (both at 11%). Concerning children living in poverty, Ogle and Henry (both at 13%) have a lower percentage than IL (16%) and Lee is slightly higher (17%). All three counties have a lower percentage of population under the age of 65 without health insurance as compared to IL (8%) and US (10%). Concerning education levels, all three counties have a higher percentage of residents with high school and some college as compared to IL and but lower for bachelors or graduate degree.



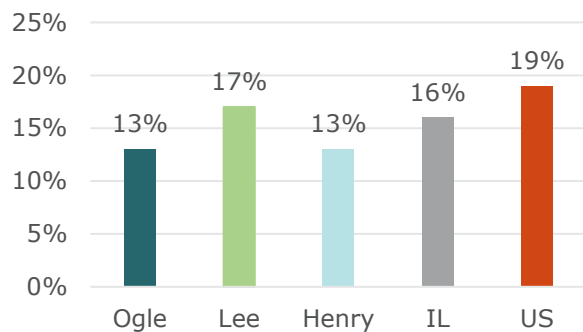
All counties have lower median household income than IL and US. Unemployment rate for Ogle is higher than the other counties, IL, and US.

### INDIVIDUALS BELOW THE POVERTY LEVEL

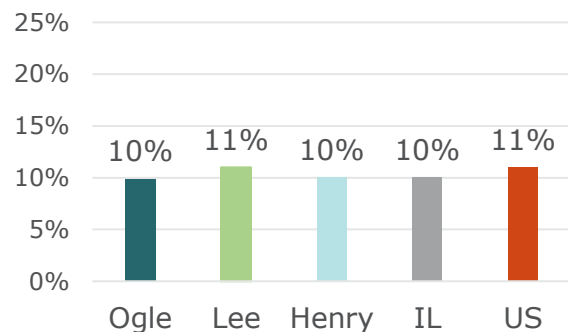


Ogle County has lower rates of those living below the poverty level as compared to the state and nation. Lee County has a higher rate of children living in poverty than Ogle and Henry.

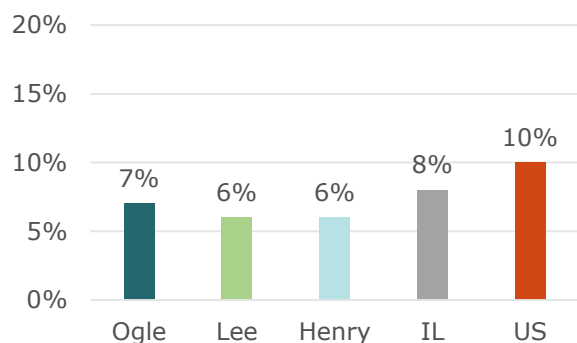
### CHILDREN IN POVERTY



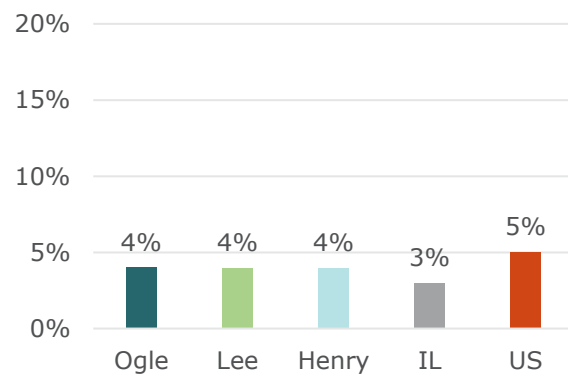
### FOOD INSECURITY



### POPULATION UNDER AGE 65 WITHOUT HEALTH INSURANCE

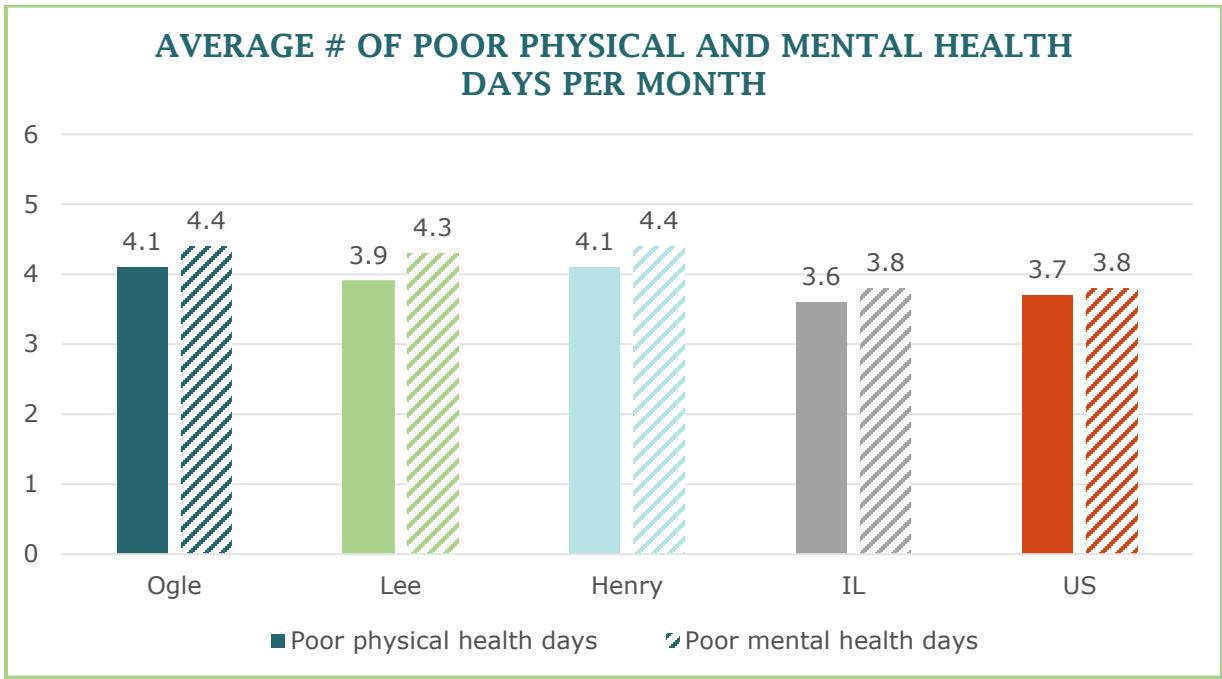


### CHILDREN WITHOUT HEALTH INSURANCE



# Quality of Life

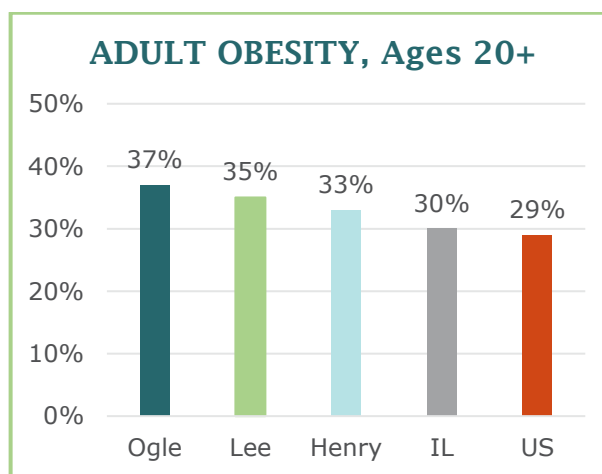
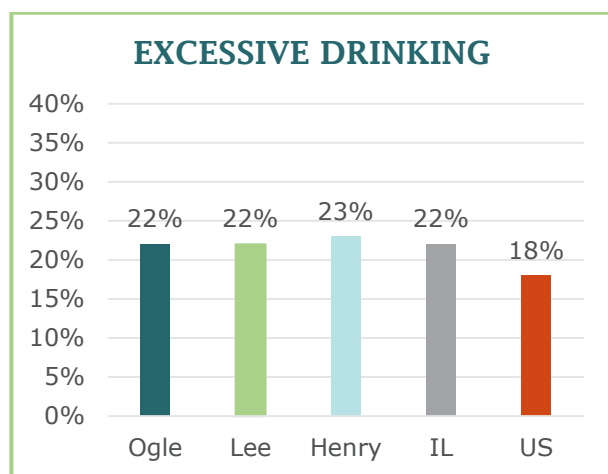
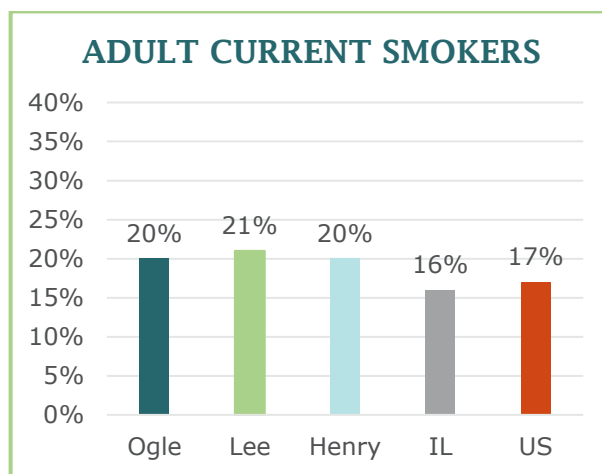
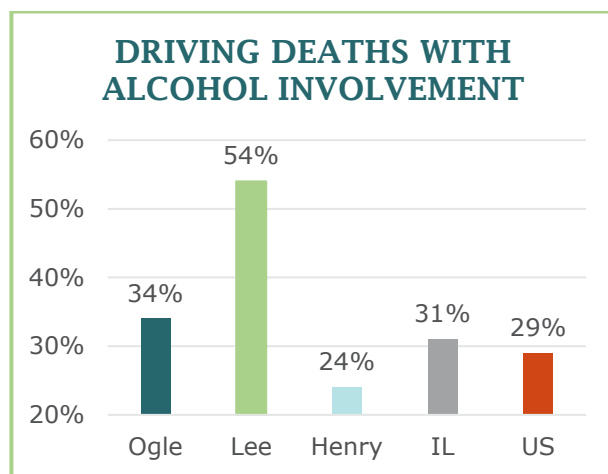
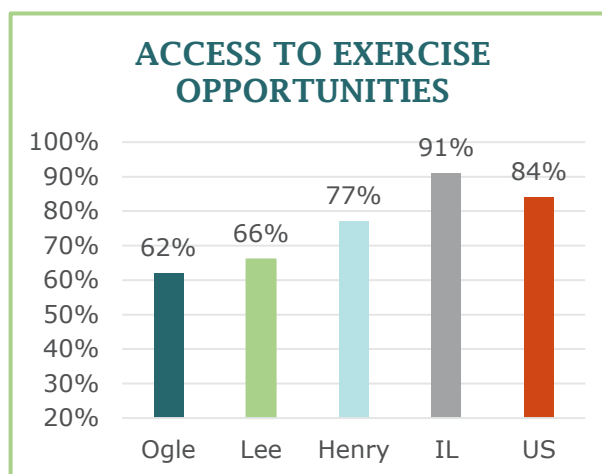
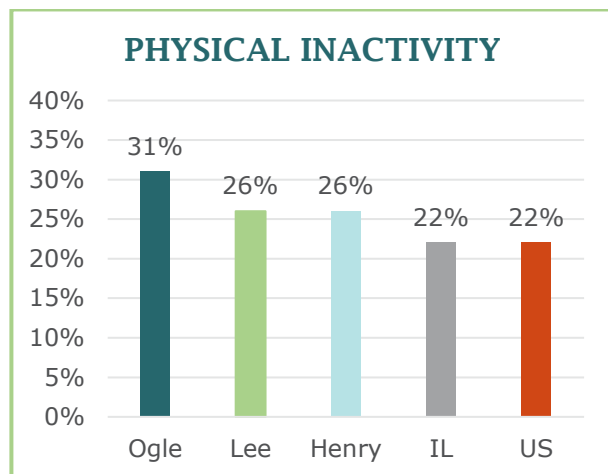
According to the data, people are reporting more poor mental health days per month compared to poor physical health days. All three counties have slightly more people experiencing poor physical and mental health days as compared to the state and nation.



# Health Behaviors

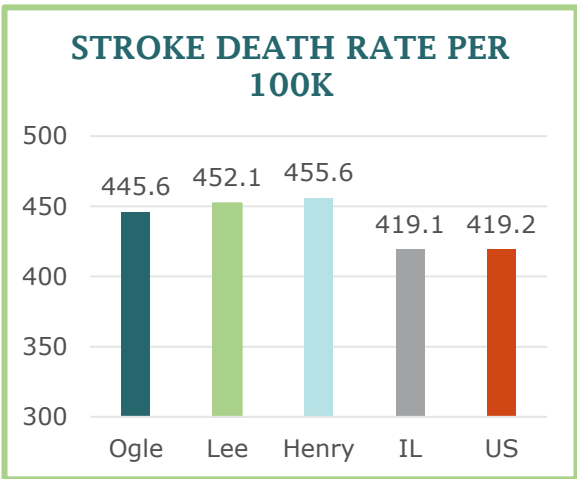
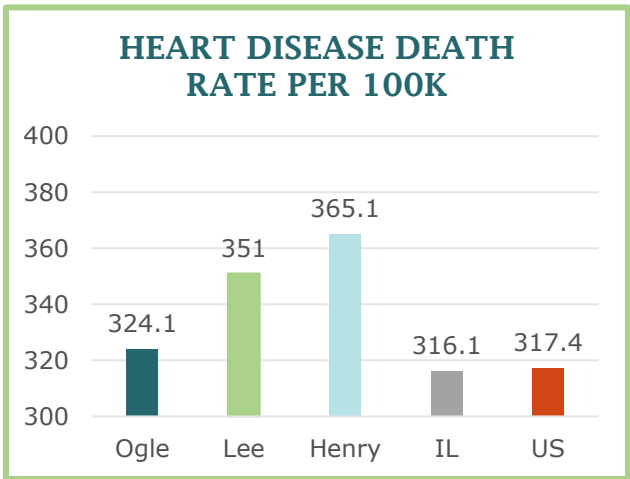
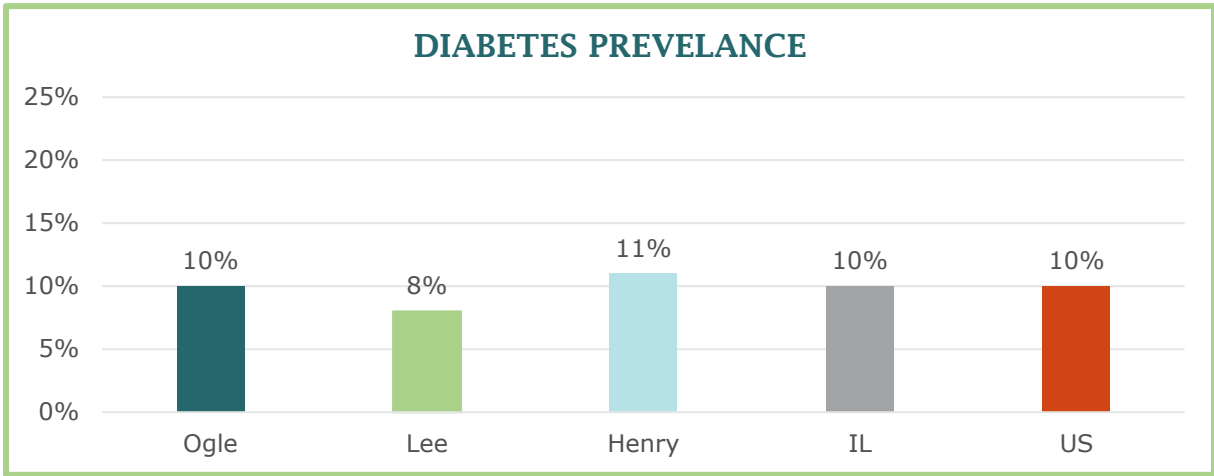
All three counties report a higher percentage of residents with physical inactivity as compared to IL and the US. In addition, they report less access to exercise opportunities compared to IL and US. Ogle and Lee counties have a high percentage of driving deaths with alcohol involvement.

Ogle (37%), Lee (35%), and Henry (33%) all report a higher percentage of the population with obesity as compared to IL (30%) and the US (29%). The same trend is found for adult smoking.

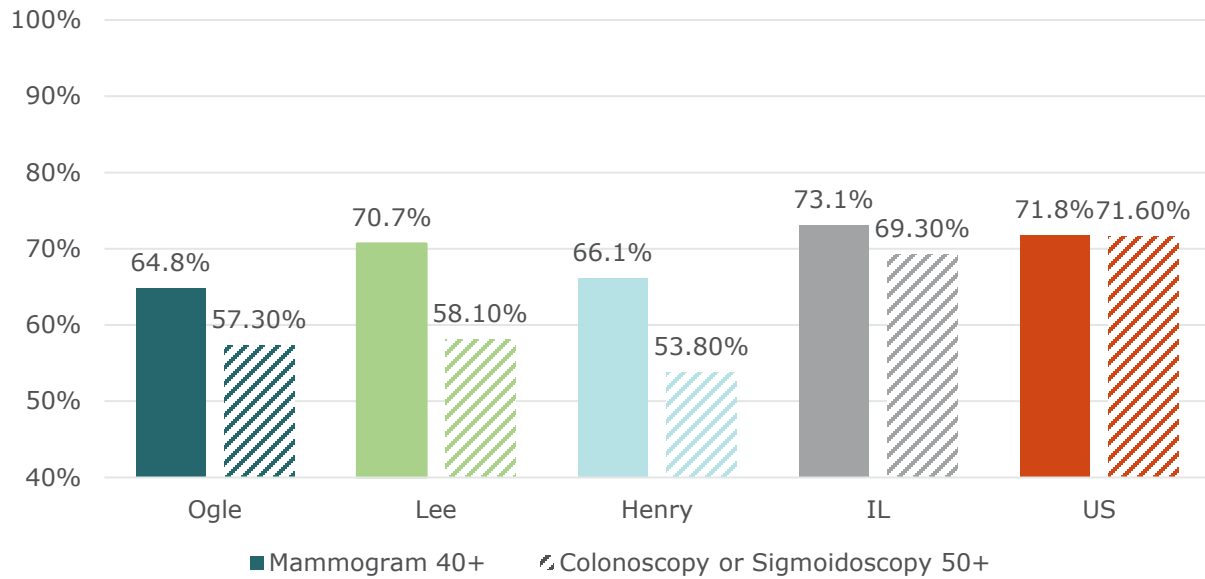


# Chronic Disease

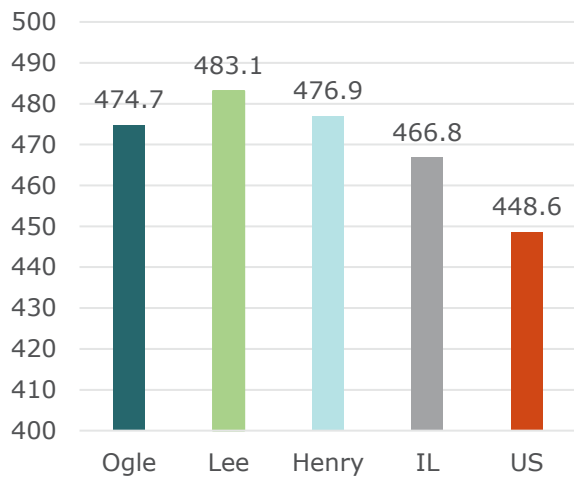
In Illinois, heart disease, followed by cancer and then stroke are the leading causes of death. All counties have an elevated stroke and heart disease death rate per 100,000 compared to state and US. Henry County has a slightly higher diabetes prevalence. Cancer rates and mortality for the three counties are higher for all counties as compared to the state and US and cancer screening rates are lower.



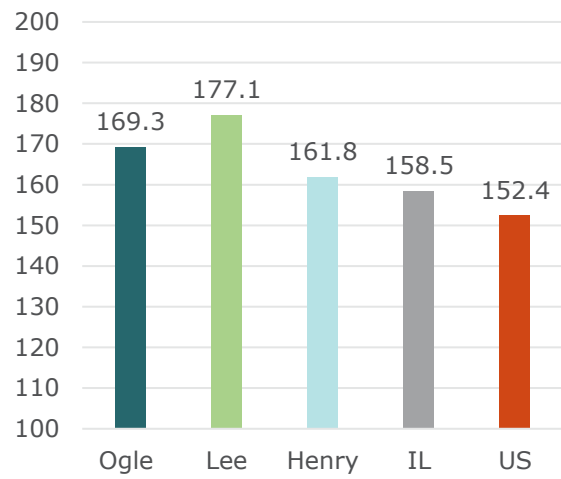
## PREVENTIVE CANCER SCREENING



## CANCER INCIDENCE RATE per 100k



## CANCER MORTALITY RATE per 100k





# Clinical Care

Concerning the ratio of county residents to each primary care physician, Ogle (1,640:1) and Lee (1,430:1) have a higher number of residents per physician as compared to IL (1,240:1) and the US (1,330:1). Henry's number is much higher at almost four times the number of residents per physician (4,240:1).

The ratio of residents to dentists for all three counties is almost double as compared to IL and the US. Regarding the ratio of residents to mental health providers, Lee (210:1) is doing better than the other two counties, IL (410:1), and the US (440:1). Ogle County's ratio for residents is higher (670:1) and like the ratio for primary care physicians, Henry's ratio (2,330:1) is more than four times that of IL and the US.



**Ratio of Population to Primary Care Physicians**

| Ogle    | Lee     | Henry   | IL      | US      |
|---------|---------|---------|---------|---------|
| 1,640:1 | 1,430:1 | 4,910:1 | 1,240:1 | 1,330:1 |



**Ratio of Population to Dentists**

| Ogle    | Lee     | Henry   | IL      | US      |
|---------|---------|---------|---------|---------|
| 2,530:1 | 2,270:1 | 2,570:1 | 1,240:1 | 1,460:1 |



**Ratio of Population to Mental Health Providers**

| Ogle  | Lee   | Henry   | IL    | US    |
|-------|-------|---------|-------|-------|
| 670:1 | 210:1 | 2,330:1 | 410:1 | 440:1 |

# Perception of Hospital Care

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a national survey that asks patients about their experiences during a recent hospital stay. RCH scores are better than the state and national averages on all questions, including rate the hospital and willingness to recommend.

| Completed surveys = 58   Response rate 28%                                       | RCH | IL  | US  |
|----------------------------------------------------------------------------------|-----|-----|-----|
| Nurses "always" communicated well.                                               | 90% | 80% | 80% |
| Doctors "always" communicated well.                                              | 94% | 80% | 81% |
| "Always" received help as soon as they wanted.                                   | 83% | 66% | 67% |
| Staff "always" explained about medicines before giving it to them.               | 71% | 62% | 63% |
| Room and bathroom were "always" clean.                                           | 89% | 73% | 73% |
| The area around their room was "always" quiet at night.                          | 78% | 64% | 63% |
| YES, they were given information about what to do during their recovery at home. | 92% | 87% | 86% |
| "Strongly agree" they understood their care when they left the hospital.         | 70% | 52% | 52% |
| Rated the hospital 9 or 10 on a scale 0-10.                                      | 86% | 72% | 73% |
| YES, they would definitely recommend the hospital.                               | 85% | 69% | 71% |

# Focus Group Findings

RHI was contracted by RCH to conduct focus group interviews to provide qualitative data on the strengths and needs of local health care services. Focus group comments reflect the perceptions of the individual.

## Background

Four focus groups were scheduled to occur over the course of two weeks in March 2022 to obtain information from community residents. RCH provided names and contact information for 96 potential attendees. RHI reached out to all 96 to invite them to participate. Attendees could choose the focus group they preferred to attend based on their availability. Each focus group included a mix of attendees representing their community. Attendees included seniors, representatives from businesses, health care consumers, and social services.

Fifteen of the 96 people signed up to attend; two did not show. Demographics of attendees based on observation and general comments and characteristics included:

- Gender: seven (7) males, six (6) females
- Estimated age: 60-70 (5); 50-59 (2); 40-49 (5), 20-39 (1)
- Employment status: 10 employed, three (3) not working/retired

Secondary data was presented to attendees at the beginning of the focus groups and included information about community population by race and ethnicity, age range, percentage of unemployed, and percentage living in poverty. Data regarding quality-of-life variables such as rates of diabetes, obesity, and adults currently smoking were also provided. Ratios of population to primary care providers, dentists, and mental health providers were also presented.

## Limitations

There are two major limitations that should be considered when reviewing these results:

1. The information is based on comments from a rather small segment of the community.
2. Participants represented are primarily middle income and appeared Caucasian. Some segments of the community may not be represented in these findings, specifically those of lower socio-economic status, (i.e., unemployed, low wage employees, etc.).

## Summary of Major Focus Group Findings

Below are the common themes in responses. The number in parenthesis ( ) indicates the number of times the item was mentioned.

- 1. Are some population groups struggling more than other groups? If yes, which ones?**
  - Hispanic (3)
  - Low income (3)
  - People with mental health issues, including parents, children, young adults, healthcare workers, those with issues that impact ability to care for self (3)
- 2. In your opinion, what are some of the barriers to accessing care within this region?**
  - Cost-specifically medications, lab and general services (7)
  - Transportation (5)
  - Insurance issues (3)
- 3. Do you use preventive health services? If not, why?**
  - Yes-11: noted they have insurance, transportation, flexible schedule
  - No-5: noted that they might not because they don't know what services are recommended, don't have insurance, language barriers
- 4. Why would you seek healthcare outside of Rochelle Community Hospital and Family Healthcare?**
  - Services not offered (4)
  - Desire for privacy (3)
- 5. How likely are you to recommend Rochelle Community Hospital to a friend or family member? Why did you give that score? (0 = Not Likely and 10 = Extremely Likely)**
  - Six participants said "10"
    - Great resource. They will send you to a higher level of care if needed. Centrally located in town.
    - They are very good at the things they know. Know what to keep and what to send to other places.
    - Hometown feel with hospital and providers. Good communication and doctors spend time with you.
    - The hospital has done a great job when I went there. We are fortunate to have them in our backyard.
    - Many experiences with them and they've done a good job.
    - Was inpatient and staff were kind and caring and food is good. ED doctor was best ever; explained in ways I could understand, great bedside manner, very good at diagnosis. They are great to make sure, if they can't provide the service you need, they will make sure you get the help you need.
  - Three participants said "8 or 9"
    - Haven't used RCH but from a business standpoint, staff are polite and communicate well.
    - RCH does a very good job
- 6. Do you feel there is a lack of mental health services in this area? What mental health services do you see the need for?**
  - Might be a need for more access to care for families who are struggling and for children who are struggling. This has been increased as a result of COVID. (2)
  - More acute care/inpatient (2)

- Work more closely with domestic violence when someone presents to hospital with an issue with this. RCH is sending a representative to attend Ogle County Strangulation Task Force and that is helpful. (2)

**7. What is the greatest health need in this community?**

- Mental health services (16)
- Prevention/screenings (6)

**8. Are there opportunities for RCH collaborate with other organizations in the community?**

- School district to provide education to students (not just 3rd graders). This would make it less scary to them or encourage them to go into those professions or they would tell their parents about services. Also, they could provide or support school nursing. (3)
- More in-depth partnership with Sinnissippi to de-stigmatize mental health issues (2)
- Meet with state representative and state senator (2)

## Key Stakeholder Findings

RHI was contracted by RCH to conduct key stakeholder interviews to provide qualitative data on the strengths and needs of local health care services.

### Background

Fifteen residents were identified by the hospital to potentially participate in key stakeholder interviews in March 2022. The key stakeholders were identified based on the various consumer groups of local health services including senior citizens, young parents, health care providers, and community leaders. Invitations were emailed with the key stakeholder questions attached or a phone call was made to invite them.

Nine people agreed to participate. In total, four men and five women participated. Three people chose to send email responses to the interview questions. Six virtual meeting sessions were approximately 20 minutes in length and included a review of the secondary data at the beginning. Each key stakeholder was asked the same questions.

### Limitations

There are three major limitations that should be considered when reviewing these results:

1. The information is based on comments from a small segment of the community.
2. Participants were all working professionals. Eight appeared to be white, with one of Hispanic ethnicity. Six participants appeared to be ages 30-45, two were in their 20s, and one was 60-70 years old. Some segments of the community may not be

represented in the findings, specifically those with lower socioeconomic status, (i.e., employed in non-professional jobs and not employed).

3. Participants were chosen as key stakeholders by RCH, which could introduce selection bias.

## Summary of Major Points

Below are the common themes in responses.

1. Which group(s) of people in your community are struggling the most?
  - Lower income residents (5)
  - Hispanic residents in Rochelle area (4)
  - Children with mental health issues (4)
    - Children 10-17, younger pre-teens
2. In your opinion, what are some of the barriers to accessing healthcare in this region?
  - Transportation (6)
  - Lack of specialty care providers in Rochelle (4) – no pediatrician, OB GYN providers/services
  - Lack of money / Cost of healthcare (5)
3. Do you use preventive health services? If not, why?
  - Yes (8); Not very much, worried about cost and feel healthy
4. Why would you seek healthcare outside of Rochelle Community Hospital and Family Healthcare?
  - Specialty care (6)
  - The costs of RCH services (3)
  - Availability – long waitlist to see a provider (2)
  - Ability to access all family healthcare needs in a continuous network (2)
5. How likely are you to recommend Rochelle Community Hospital to a friend or family member? (0 = Not Likely and 10 = Extremely Likely)
  - 10 (5); 8 (3); 6 (1)
6. Why did you give that score?
  - Great communication with hospital leaders, very community minded, staff is friendly, qualified providers who can provide critical care or first point of care.
  - Cost of services
  - It depends on what service I am recommending and/or the sense of urgency in receiving those health services.

7. Do you feel there is a lack of mental health services in this area? What mental health services do you see the need for?
- Yes (8); Unsure (1)
  - Mental health services for youth (3)
  - Psychiatrists (3)
    - especially those who see children
  - Address the stigma of mental health and substance use (2)
  - Affordable services, providers for kids/youth, more mental health providers, better federal/state funding for services, better coordinated care, tele-behavioral health services, and counselors were all mentioned
8. What do you think is the greatest health need in this community?
- Mental health services (5)
  - OB/GYN services (3)
  - Primary care (2)
  - Pediatric care (2)
9. Are there opportunities for RCH to collaborate with other organizations in the community?
- Sinnissippi (2) - partner and collaborate to coordinate care better
  - Opportunities to partner more with faith-based organizations, city, townships, parks, YMCA, other civic organizations, health department, schools, Spanish speaking volunteers, factories, senior center, mental health organizations, chamber of commerce, Hope domestic violence shelter and Focus House

# Conclusions, Recommendations, and Acknowledgements

## Conclusions

Public perception of Rochelle Community Hospital (RCH) is consistent with the findings from the 2019 CHNA. The hospital is perceived very favorably by the community according to those attending the focus groups and key stakeholders. Most interviewees indicated that they would recommend the hospital to friends and family. This is also consistent with HCAHPs data; RCH scores higher in all composites as compared to Illinois and US. RCH is identified as the hospital of choice and feedback indicates that community members seek care elsewhere only when it is not available at RCH or when cost or medical coverage is a factor.

The top health concern identified in the focus groups and stakeholder interviews was the need for additional mental health services. The need for more family, children, and adolescent services was mentioned, especially because of the pandemic and the challenges of isolation, remote learning, increased alcohol consumption, depression, anxiety, financial issues, and the overall increase of stress. It is noted in the secondary data, that respondents from Ogle (4.4), Lee (4.3), and Henry (4.4) counties report more “poor mental health days per month” than Illinois or the US (3.8 for both). When looking at secondary data for the ratio of residents to mental health providers, Henry County had a much poorer ratio (2,330:1), Ogle County had a poorer ratio (670:1), and Lee County had a better ratio (210:1) as compared to Illinois (410:1) and the US (440:1). The need for acute care for mental illness was also identified, and this is true for most communities as inpatient mental health services are less available. The third most common suggestion for both focus groups and stakeholder interviews included the focus on addressing stigma that is associated with seeking services.

Another common health concern identified in the focus groups and stakeholder interviews was the lack of local obstetric and gynecology services. Both also noted the need for other specialties such as pediatric care or “birth to adult” services. The need for more primary care was mentioned as well. Secondary data indicates the ratio for residents to primary care providers is worse for all counties, Henry (4,910:1), Ogle (1,640:1), and Lee (1,430:1) as compared to Illinois (1,240:1) and the US (1,330:1).

Another common health concern involved the need for more preventative services and free screenings. There is a higher percentage of smokers for all counties (Ogle and Henry at 20% and Lee at 21%) as compared to Illinois (16%) and US (17%). All counties have a higher percentage of obesity (Ogle at 37%, Lee at 35%, Henry at 33%) as compared to Illinois (30%) and US (29%). All counties have elevated stroke and heart disease death rates compared to state and US as well.

## Recommendations

RCH has an opportunity to continue their past work to positively impact the health of the community. It is recommended that the hospital identify ways to address some of the findings from the focus groups, key stakeholder interviews, and secondary data by focusing on wellness. This could include initiatives to impact many of the areas addressed above - mental health and stigma, smoking, obesity, and heart disease - by maximizing education and preventative resources and services. To do this, it is important to leverage current and potential partnerships in the community. It was noted that RCH engages well with other organizations, including Sinnissippi and the school system. There may be an opportunity to develop new partnerships with civic groups, faith-based groups, and businesses. Hospitals



are finding that educational events are most effective when they involve the collaboration with other groups and are held outside the hospital walls.

In addition to the focus on wellness, the community is asking for more mental health services, especially for families and children. Tele-health is providing one way to reach more people, especially when transportation or other factors are a barrier. It's important to explore other options as well. This might include working with faith-based or pastoral care groups, maximizing collaboration with Sinnissippi, and identifying non-traditional partners.

## Acknowledgements

RHI would like to thank RCH's Chief Financial Officer, Lori Gutierrez and Kim Louis, Executive Assistant, for their contributions and work with developing and coordinating the focus groups and key stakeholder interviews.

**Ogle County Health Department  
Ogle County Community Health Assessment and Plan**

**2025 – 2030**

**Mobilizing for Action through Planning and Partnerships:  
A Strategic Approach to Community Health**

**For  
Illinois Department of Public Health  
Springfield, Illinois**

**October 2025**

**Prepared By**

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## Acknowledgements

Deciding to engage in a community assessment process is not a frivolous undertaking. Many individuals and organizations have played an integral role in this endeavor in multiple communities and through many different vehicles. Several of the central themes of this report came through assessment processes led by other organizations for other purposes, but are intricately related to a shared responsibility for public health and the overall health, well-being, and quality of life of all of our residents. For that reason, the Ogle County Health Department would like to acknowledge the staff that played an important role in the formulation and development of this document:

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## **Community Health Needs Assessment and Plan**

### **Summary of Process**

#### **Statement of Purpose**

Public health departments throughout the United States currently focus on 10 Essential Services. These Essential Services were expanded upon from three original core functions: Assessment, Policy Development, and Assurance. Originally identified by the Institute of Medicine, they became the foundation for every public health department in the country (Institute of Medicine, 1988). Throughout this paper, the concentration will center on the assessment function of public health in regards to the health of the populations within Ogle County.

As per the Illinois Administrative Code, every health department within the state must “assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of the community” (Illinois Department of Public Health, 2017). Community assessment is a crucial function for a public health department, as it aids in its responsibilities to monitor the local health status, but it also provides the opportunity to analyze and address health problems and hazards within the community. The Ogle County Health Department is then able to target these identified community health problems through the implementation of policies and plans and advocate for them within the larger public health system. Through this assessment function, the public health system is provided with guidelines as to how to more efficiently address health problems within each jurisdiction.

The objective of our department has been to construct an assessment process that would include as much participation as possible, as we desired community-wide contributions in regard to the health issues most affecting the community as a whole. Our department aimed to use the most comprehensive perspective of health as possible, as to include a large range of contributions from both area residents and also local service providers. Various factors influence health, shifting from individual behaviors and genetics, to larger scale environmental factors like physical and social environments which a community may find themselves in.

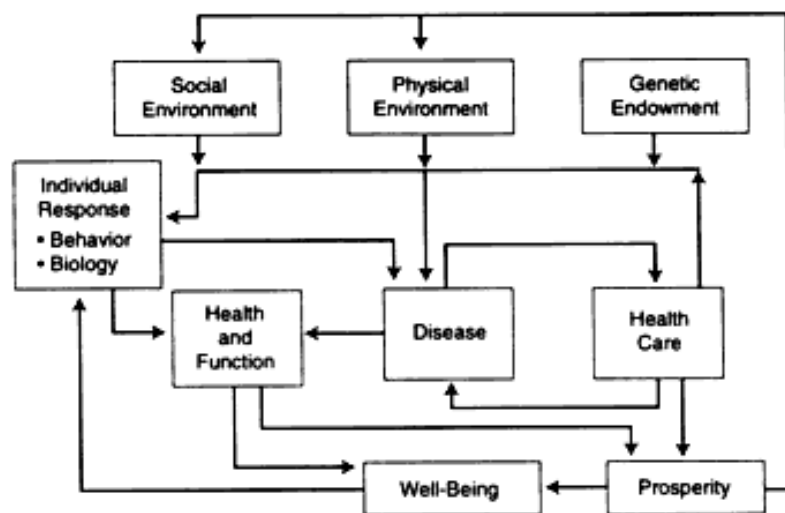
Health is a concept that encompasses both an individual’s well-being and also their being devoid of illness. The Institute of Medicine recognized this fact in regard to health being a dynamic state, discussing how there is a wider recognition of this idea in many different settings (Institute of Health, 1997). Because of this idea, health is viewed as a combination of social and personal resources along with physical capabilities.

Additionally, this definition stresses the key contributions that affect health and come from areas outside of formal medical care and public health systems. Health is not solely dependent on medical care, but rather it is also determined by other factors and could include

individual behavior, genetic makeup, and social and economic conditions. This is true for both individuals as well as populations.

The Health Field Model depicts the multiple determinants of health and the dynamic relationship of each one on another (Evans and Stoddart, 1994). The model links social

**Figure I The Health Field Model**



Reference: Evans, R.G. & Stoddart, G.L. (1990). Producing health, consuming health care. *Social Science & Medicine* (1982), 31(12), 1347-1363.

environment, physical environment, genetic endowment, health care, disease, health and function, well-being, prosperity, and individual response (both behavioral and biological). This model provides a multidimensional perspective, which emphasizes the importance of a population-based approach to community health issues. It also indicates the potential

influences that both public and private entities, such as health care providers, public health agencies, and community organizations, can have on the health of a community. Additional stakeholders could include other government agencies, community organizations, and organizations and individuals in private industry. Other entities that may not be solely health centered such as schools, employers, social service and housing agencies, transportation and justice agencies, and faith communities which can all influence the health of a community. Because of these interactions and influences that all affect health, the Ogle County Health Department elected to engage with a diverse audience throughout this assessment process, and build upon assessments conducted locally.

## Community Participation Process

The key elements of this community assessment were supported by local community-based coalitions. These representatives came from local governments, churches, businesses, civic organizations, and health care providers. This diverse representation, working in collaboration with one another during multiple assessment processes, aided in the overall completion of the community assessment for our service area. We relied heavily on assessment processes fulfilled by our local hospital, the Rochelle Community Hospital, in integrating our results within the larger community context.

## Methodology

The Ogle County Health Department elected to use MAPP (Mobilizing for Action through Planning and Partnerships), an assessment model developed by the National Association of County and City Health Officials and the Centers for Disease Control and Prevention, to conduct the assessment. MAPP is a strategic planning tool that focuses on improving health throughout the community (National Association of County and City Health Officials, 2001). It is promoted by public health leadership and aids communities in prioritizing their community health issues and also in analyzing resources available to address them. There are four different assessment processes that are included in the MAPP Model. These processes each provide important understanding about challenges and opportunities throughout the community. These processes include:

1. **Community Themes and Strengths Assessment**, which aids in identifying issues of interest for the community, community perceptions about quality of life, and also community assets.
2. **Local Public Health System Assessment**, which measures the capacity and performance of the local public health system—all the organizations and entities that contribute to the public's health.
3. **Community Health Status Assessment**, which analyzes data available about health status, quality of life, and risk factors that exist in the community.
4. **Forces of Change Assessment**, which identifies present or forthcoming forces affecting the community or local public health system.

Through the use of this assessment, local participants are able to determine strategic health issues within the community and then create goals and strategies to address these issues. The information collected is vital for the action cycle, because it is during this cycle that participants plan for action, implement, and evaluate. Successfully conducting a MAPP assessment should create a sustainable community initiative that will conclusively end with overall community health

**Figure 2 MAPP Model**



Reference: National Association of County and City Health Officials. (2001). *Mobilizing for action through planning and partnerships*. Washington, D.C.: National Association of County and City Health Officials.

improvement.

The Community Health Needs Assessment included an extensive review and analysis of community specific data associated with demographic and socioeconomic characteristics, general health and access to care indicators, maternal and child health indicators, chronic disease indicators, infectious disease indicators, and environmental/occupational/injury data. This data was collected and reviewed from multiple sources such as the IPLAN Data System, the Behavioral Risk Factor Surveillance System (BRFSS), County Health Rankings, the Rochelle Community Hospital Health Assessment, and other assessment results. After reviewing and analyzing community-specific data from these various sources, opinions were gathered from diverse audiences throughout the service area to complement the data collection.

Data that was reviewed and analyzed at this stage of the assessment process will be discussed throughout this report in more depth. A portion of the analysis included a compilation of data over time from the County Health Rankings and is located in the Appendix. Other assessments and reports published recently by the Rochelle Community Hospital were also reviewed and analyzed to ascertain if common themes existed throughout. Additionally, a student group from Illinois Wesleyan University compiled secondary data to assist our collection processes.

The assessment relied on quantitative data from secondary data sources, and also on qualitative data provided in multiple focus groups that our agency participated in across the county, and numerous online surveys. These focus groups included participants representing:

Ogle County Cares

Rochelle Community Hospital



## Summary of Available Data

### Demographic and Socioeconomic Characteristics

Ogle County is considered to be a Micropolitan. Micropolitan is defined by Merriam-Webster as “of, relating to, or being a population area that includes a city with 10,000 to 50,000 residents and its surrounding communities” (Webster 2024). Ogle County is connected to the city of Rockford, IL. 67.9% of the population in Ogle County lives in a low population density area. This means residing in a region where there are few people per square mile, leading to more spread-out communities, larger distances between homes, and less human activity compared to densely populated urban areas. In essence, it refers to living in a place where the number of people is small relative to the available land.

The following is a chart demonstrating the most recent demographic data in Ogle County, collected in 2024.

|                                                       | Ogle County | Illinois   |
|-------------------------------------------------------|-------------|------------|
| <u>Population **</u>                                  | 51,351      | 12,582,032 |
| <u>% Below 18 Years of Age **</u>                     | 21.9%       | 21.6%      |
| <u>% 65 and Older **</u>                              | 19.9%       | 17.2%      |
| <u>% Non-Hispanic Black **</u>                        | 1.2%        | 14.1%      |
| <u>% American Indian or Alaska Native **</u>          | 0.4%        | 0.6%       |
| <u>% Asian **</u>                                     | 0.7%        | 6.3%       |
| <u>% Native Hawaiian or Other Pacific Islander **</u> | 0.1%        | 0.1%       |
| <u>% Hispanic **</u>                                  | 11.5%       | 18.3%      |
| <u>% Non-Hispanic White **</u>                        | 85.1%       | 59.5%      |
| <u>% Not Proficient in English **</u>                 | 1%          | 4%         |
| <u>% Female **</u>                                    | 49.8%       | 50.5%      |
| <u>% Rural **</u>                                     | 67.9%       | 13.1%      |

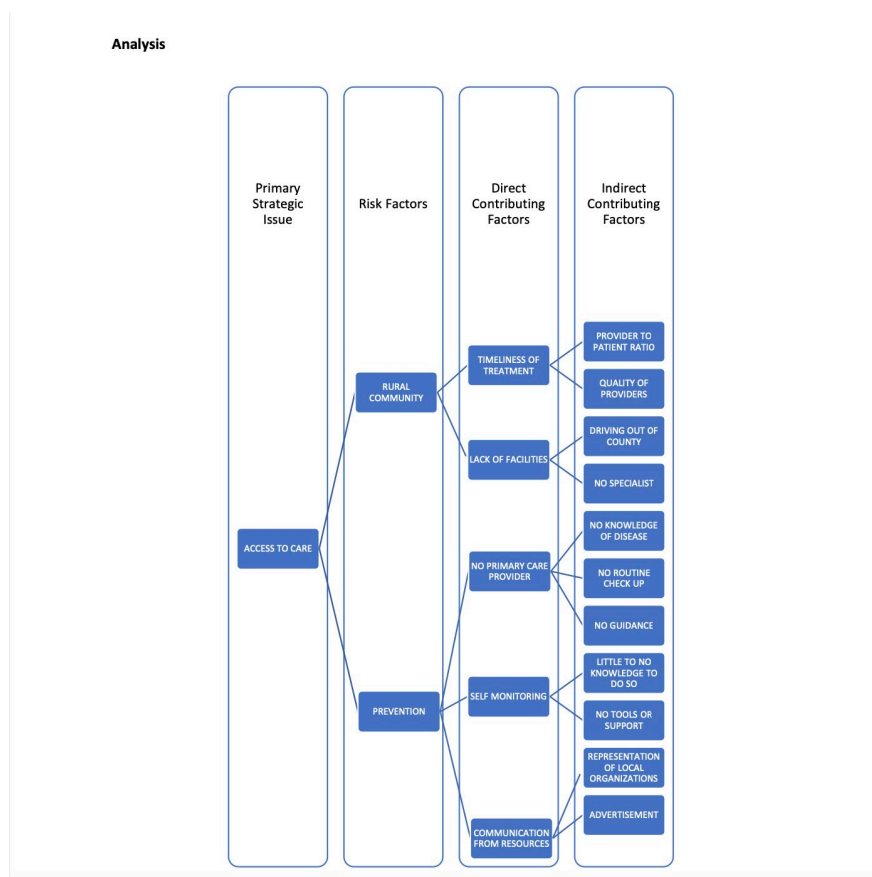
The following is the U.S. Census data on Ogle County from the most recent 2023 census:

|                                                                                      |          |
|--------------------------------------------------------------------------------------|----------|
| <b>Transportation</b>                                                                |          |
| <b>i</b> Mean travel time to work (minutes), workers age 16 years+, 2018-2022        | 27.0     |
| <b>Income &amp; Poverty</b>                                                          |          |
| <b>i</b> Median household income (in 2022 dollars), 2018-2022                        | \$75,782 |
| <b>i</b> Per capita income in past 12 months (in 2022 dollars), 2018-2022            | \$36,436 |
| <b>i</b> Persons in poverty, percent                                                 | ⚠ 8.5%   |
| <b>Computer and Internet Use</b>                                                     |          |
| <b>i</b> Households with a computer, percent, 2018-2022                              | 90.8%    |
| <b>i</b> Households with a broadband Internet subscription, percent, 2018-2022       | 85.1%    |
| <b>Education</b>                                                                     |          |
| <b>i</b> High school graduate or higher, percent of persons age 25 years+, 2018-2022 | 91.3%    |
| <b>i</b> Bachelor's degree or higher, percent of persons age 25 years+, 2018-2022    | 23.4%    |
| <b>Health</b>                                                                        |          |
| <b>i</b> With a disability, under age 65 years, percent, 2018-2022                   | 10.0%    |
| <b>i</b> Persons without health insurance, under age 65 years, percent               | ⚠ 6.1%   |
| <b>Age and Sex</b>                                                                   |          |
| <b>i</b> Persons under 5 years, percent                                              | ⚠ 5.3%   |
| <b>i</b> Persons under 18 years, percent                                             | ⚠ 22.1%  |
| <b>i</b> Persons 65 years and over, percent                                          | ⚠ 20.4%  |
| <b>i</b> Female persons, percent                                                     | ⚠ 50.0%  |
| <b>Race and Hispanic Origin</b>                                                      |          |
| <b>i</b> White alone, percent                                                        | ⚠ 95.6%  |
| <b>i</b> Black or African American alone, percent (a)                                | ⚠ 1.5%   |
| <b>i</b> American Indian and Alaska Native alone, percent (a)                        | ⚠ 0.5%   |
| <b>i</b> Asian alone, percent (a)                                                    | ⚠ 0.7%   |
| <b>i</b> Native Hawaiian and Other Pacific Islander alone, percent (a)               | ⚠ 0.1%   |
| <b>i</b> Two or More Races, percent                                                  | ⚠ 1.6%   |
| <b>i</b> Hispanic or Latino, percent (b)                                             | ⚠ 12.1%  |
| <b>i</b> White alone, not Hispanic or Latino, percent                                | ⚠ 84.5%  |
| <b>Population Characteristics</b>                                                    |          |
| <b>i</b> Veterans, 2018-2022                                                         | 3,657    |
| <b>i</b> Foreign born persons, percent, 2018-2022                                    | 3.7%     |

(Census.gov 2023)

## General Health and Access To Care

According to Ogle County's Illinois Project for Local Assessment of Needs (IPLAN), 4.67% of the Ogle County population are uninsured. This is lower than the state at 6.83% and the nation at 8.84%. Being uninsured is significant because it limits access to healthcare, increases the risk of poorer health outcomes, and can result in financial burdens from unexpected medical bills. It impacts the ability or want to seek medical care. The IPLAN also reports that the rate of preventable hospitalizations in Ogle County is at 4,923 per 100,00 Medicare beneficiaries. The following is the analysis of the Access to Care Outcome Issue and Factors from 2022:



(oglecountyil.gov 2020)

The following are ratios demonstrating the most recent demographic data in Ogle County, collected in 2024.

|             | Primary care physicians | Dentists | Mental health providers |
|-------------|-------------------------|----------|-------------------------|
| Ogle County | 1640:1                  | 2530:1   | 670:1                   |

(oglecountyil.gov 2020)

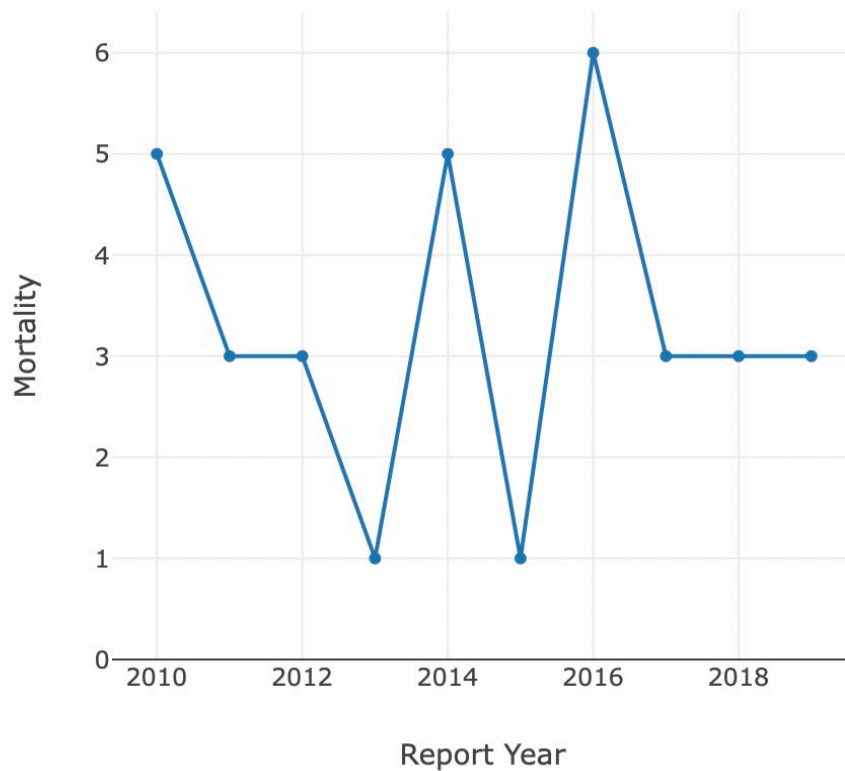
## Maternal and Child Health

The following is a chart demonstrating the most recent birth characteristic data in Ogle County compared to the state of Illinois, collected in 2022:

|             | Adequate Parental Care | Mother Unmarried | Cesarean | Preterm | Low Birth Weight | Non HS graduate age 20+ | Very low birth weight |
|-------------|------------------------|------------------|----------|---------|------------------|-------------------------|-----------------------|
| Illinois    | 98,878                 | 50,565           | 39,771   | 13,587  | 11,158           | 8,710                   | 1,799                 |
| Ogle County | 442                    | 197              | 158      | 46      | 44               | 36                      | 7                     |

(illinois.gov 2022)

The following chart is represents the most recent data on infant mortality in Ogle County, collected in 2019 and broken down by year.



(oglecountyil.gov)

The following is a chart from the Ogle County Health Department's Annual Report from 2022 of the Maternal Child Health Programs and the amount of participation they have received:

## Maternal Child Health Programs

### Enrollment

|                            |      |
|----------------------------|------|
| Average Number of Infant   | 102  |
| Average Number of Women    | 89   |
| Average Number of Children | 195  |
| Total Number of Children   | 2341 |

### Visits

|                  |      |
|------------------|------|
| Total WIC Visits | 1953 |
|------------------|------|

### Breast Feeding

|                                                             |       |
|-------------------------------------------------------------|-------|
| Average Percentage of WIC Infants Exclusively Breastfeeding | 14.7% |
|-------------------------------------------------------------|-------|

### Screenings

|               |    |
|---------------|----|
| Developmental | 51 |
| Prenatal      | 58 |
| Postpartum    | 79 |
| EPSDT         | 2  |

## Chronic and Infectious Disease

The University of Washington's Institute for Health Metrics and Evaluation (IHME) assessed the health outcomes of all 3,142 U.S. counties or county-equivalents, focusing on life expectancy at birth, mortality rates for specific causes, alcohol consumption, smoking rates, obesity prevalence, and recommended physical activity. This analysis utilized innovative small-area estimation methods and the latest county-level data. Collected from 2014-2016, although this data is more historical, it can provide insight on changes in the present day of various health problems, and can confirm trends in health issues seen today as they progressed or improved. The following data is a summary of Ogle Counties data from 2016, and comparisons to the state of Illinois and National Data:

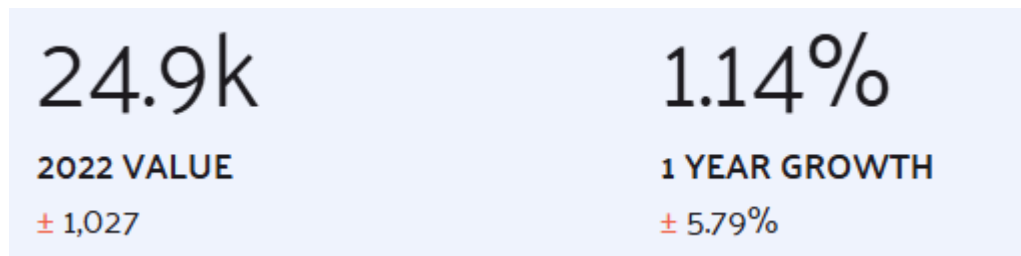
| Topic                                                                        | Ogle County        | Illinois           | National           | National Rank      |
|------------------------------------------------------------------------------|--------------------|--------------------|--------------------|--------------------|
| Life expectancy at birth (in years)                                          | 79.65              | 79.0               | 79.1               | 862                |
| Cerebrovascular Disease (stroke) (rate per 100,000)                          | 52.4               | 50.0               | 47.2               | 1582               |
| Malignant Skin Melanoma (rate per 100,000 population)                        | 3.0                | 3.1                | 4.0                | 2054               |
| Self-Harm and Interpersonal Violence Mortality (rate per 100,000 population) | F: 6.9<br>M: 26.2  | F: 6.9<br>M: 28.1  | F: 9.0<br>M: 30.9  | F: 532<br>M: 785   |
| Transport Injuries Mortality (rate per 100,000 population)                   | F: 12.3<br>M: 25.4 | F: 6.4<br>M: 14.6  | F: 8.1<br>M: 19.8  | F: 1301<br>M: 1030 |
| Binge Drinking (% , age-standardized)                                        | F: 16.0<br>M: 29.3 | F: 15.9<br>M: 28.8 | F: 12.4<br>M: 24.5 | F: 2688<br>M: 2426 |
| Smoking (% , age-standardized)                                               | 22.1               | 20.3               | 19.1               | 1004               |
| Obesity                                                                      | 36.1               | 35.1               | 36.5               | 975                |

(IHME 2016)

This data provides unique insight on the problems from eight years ago in Ogle County. This can be used to assess if significant change has been made in these health problems in Ogle County.

## Environmental/Occupational/Injury Control

Between 2021 and 2022, the number of jobs in Ogle County, IL went up by 1.14%, increasing from 24.6k to 24.9k employees. The top job sectors for people living in Ogle County, IL are Manufacturing (4,281 people), Health Care & Social Assistance (3,503 people), and Retail Trade (2,735 people).



(DataUSA.io)

## Sentinel Events

Sentinel events are unexpected events or incidents that have an effect on the community. They highlight urgent needs, and challenge existing systems. The one sentinel event that has occurred in Ogle County was a public health crisis. The COVID-19 pandemic started in March 2020, and is still ongoing. In 2021, there were 6,004 confirmed cases in the reported area. The rate of confirmed cases was 11,790.35 per 100,000 population. That was greater than the state average of 10,530.28. There were a total of 80 deaths among patients with the virus.

## Complete Results

### I. Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment is crucial to understanding opinions and concerns about quality of life within a community. Thoughts are collected from the community along with community assets to determine community health concerns and available assets to address them. The information collected from this assessment helps to provide an account of the community through the perspective of the community members themselves. Responses from a portion of the assessment were obtained through an online assessment that was coordinated by students enrolled in the HLTH 240: Foundations of Health Education/Health Promotion course at Illinois Wesleyan University. The assessment here included open-ended questions, but also asked residents to rate their community on a 5-point Likert scale.

Using thorough group research, it was decided to have two options for the community assessment tools for the evaluation of Ogle County's community themes and strengths. The site coordinator chose to use the Advancing Partners community themes and strengths assessment. With this data, priorities were established that included community strengths, quality of life, health care, and what can be improved. The participants were also questioned regarding Ogle County's public health system, covering topics such as the significance of health issues in the community and health education on these varying health issues. By utilizing these questions, we hope to follow the Illinois State Health Improvement Plan that was selected to implement the following health priorities for 2028: "access to health care and wrap-around services, physical

and built environment, public health system infrastructure, racial equity, and social and structural determinants (Illinois State Health Improvement plan).

We attempted to create community participation and identify health problems in Ogle County by asking 25 questions about education, healthcare, and overall quality of life. Our group sent out a Google form asking these questions. Although response rates were low, the responses below may provide a general summary of these open-ended qualitative questions:

## Ogle County

### ***Q. What do you feel is important in your community?***

“Having access to appropriate health care and language services.”

“Aligning resources with needs.”

“Having access to cost-effective health services such as regular health screenings, medical care, medications, vaccinations, and laboratory services.”

### ***Q. How do you perceive quality of life in your community?***

“It is perceived well.”

“Average”

“Quality of life is perceived as clean and safe.”

### ***Q. What assets do we have in this community that could help improve community health?***

“Networks and good leaders.”

“Health department, food pantry, mental health services, community organizations.”

Additionally, we elicited other feedback utilizing a second survey of residents. Below is a summary of their responses with the number of responses noted in parentheses:

### ***Q: What are the 3 greatest STRENGTHS of Ogle County? Please select only 3:***

|                                   |             |
|-----------------------------------|-------------|
| Friendly Community                | 32.47% (63) |
| Affordable Housing                | 8.25% (16)  |
| Police, Fire, and Rescue Services | 40.21% (78) |
| Parks and Recreation              | 38.66% (75) |



|                                                             |             |
|-------------------------------------------------------------|-------------|
| Good Schools                                                | 36.60% (71) |
| Prepared for Emergencies (tornadoes, floods, disease, etc.) | 8.25% (16)  |
| Access to Health Care                                       | 10.31% (20) |
| Low crime/Safe neighborhoods                                | 28.87% (56) |
| Walkable, Bikeable Community                                | 15.46% (30) |
| Senior Services                                             | 16.49% (32) |
| Access to alcohol/drug treatment                            | 2.06% (4)   |
| Programs for youth outside of school                        | 5.67% (11)  |
| Arts and Cultural Events                                    | 8.76% (17)  |
| Clean Environment                                           | 20.10% (39) |
| Religious/Spiritual Values                                  | 5.67% (11)  |
| Access to Child Care                                        | 2.58% (5)   |
| Good jobs and healthy economy                               | 3.61% (7)   |
| Early Childhood Services                                    | 3.09% (6)   |
| Homeless Services                                           | 0.52% (1)   |
| Help for Veterans                                           | 0.52% (1)   |
| Access to affordable, healthy food                          | 2.58% (5)   |
| Technology/Internet Access                                  | 3.61% (7)   |
| Public Transportation                                       | 0.52% (1)   |

**Q:     *Where should the community focus its attention to make things better in Ogle County?***  
***Please select only 3:***

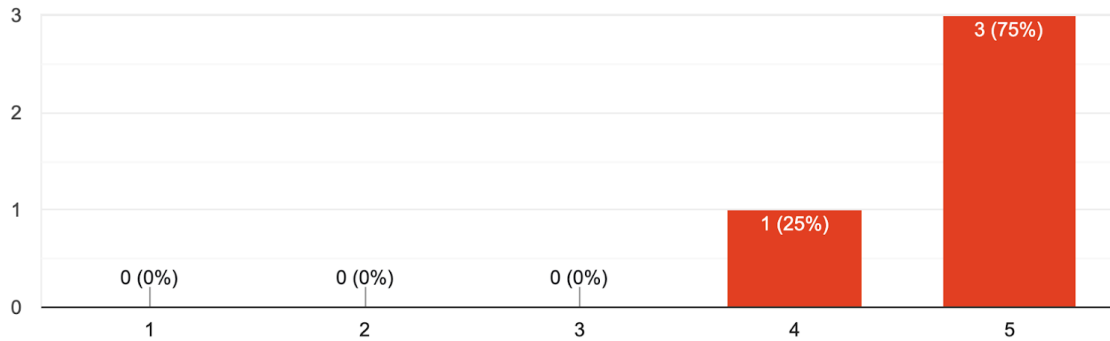
|                                   |             |
|-----------------------------------|-------------|
| Access to Mental Health Treatment | 45.88% (89) |
| Access to Alcohol/Drug Treatment  | 23.20% (45) |
| Access to Childcare               | 17.01% (33) |
| Access to Healthcare              | 14.43% (28) |
| Police, Fire, and Rescue Services | 7.22% (14)  |

|                                                       |             |
|-------------------------------------------------------|-------------|
| Affordable Housing                                    | 26.80% (52) |
| Reduced bullying                                      | 10.31% (20) |
| Good Jobs and Healthy Economy                         | 23.20% (45) |
| Programs for youth outside of school                  | 14.43% (28) |
| Low Crime/Safe Neighborhoods                          | 6.70% (13)  |
| Stress Management                                     | 6.20% (12)  |
| Senior Services                                       | 10.31% (20) |
| Walkable/Bikeable Community                           | 8.76% (17)  |
| Homeless Services                                     | 8.76% (17)  |
| Public Transportation                                 | 9.79% (19)  |
| Information on how to be healthy                      | 7.73% (15)  |
| Healthy Moms and Babies                               | 4.64% (9)   |
| Early Childhood Services                              | 7.22% (14)  |
| Faith Communities                                     | 4.12% (8)   |
| Clean Environment                                     | 4.12% (8)   |
| Schools                                               | 6.70% (13)  |
| Respect towards different cultures and races          | 9.28% (18)  |
| Arts and Cultural Events                              | 2.58% (5)   |
| Parks and Recreation                                  | 5.15% (10)  |
| Access to Special Needs Housing                       | 4.64% (9)   |
| Technology/Internet Access                            | 2.06% (4)   |
| Sexually Transmitted Infections                       | 0.52% (1)   |
| Family planning                                       | 0.52% (1)   |
| Prepared for Emergencies (tornadoes, floods, disease) | 0.52% (1)   |
| Violence                                              | 0.52% (1)   |

Twelve Likert Scale format questions about quality of life were also asked of residents. Responses were on a five-point scale with 5="yes". Responses are displayed in graph form below:

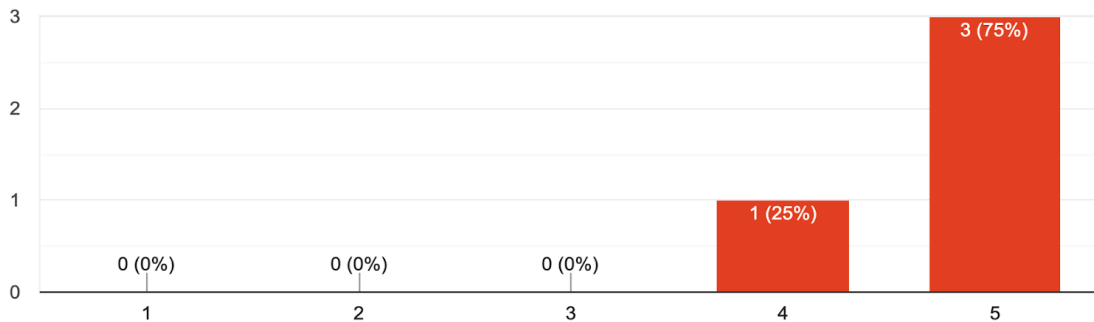
4. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.)

4 responses



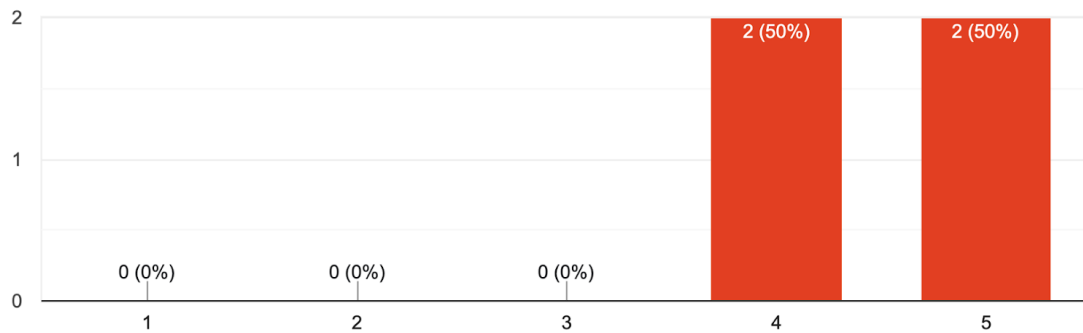
6. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)

4 responses



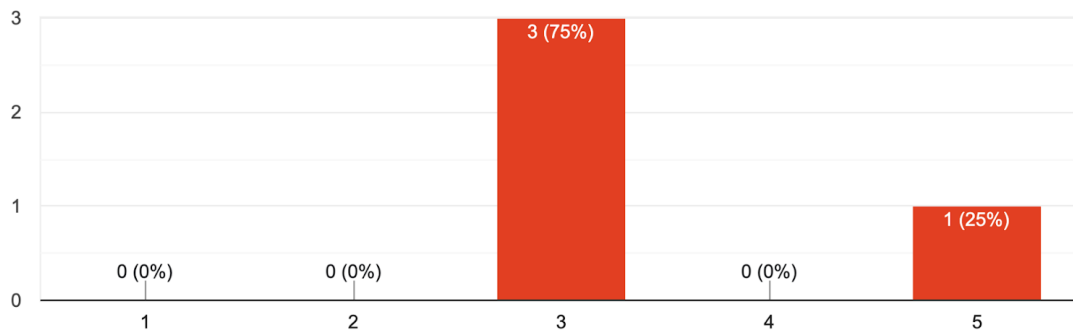
7. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping, elder day care...for the elderly living alone, meals on wheels, etc.)

4 responses



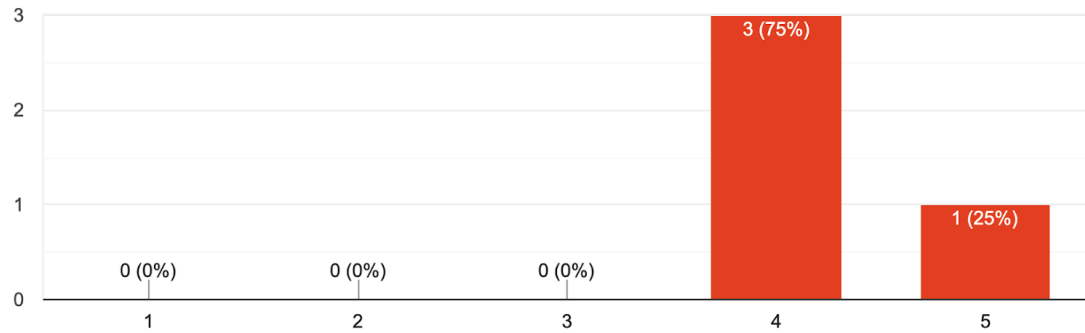
8. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/h...ties, affordable housing, reasonable commute, etc.)

4 responses



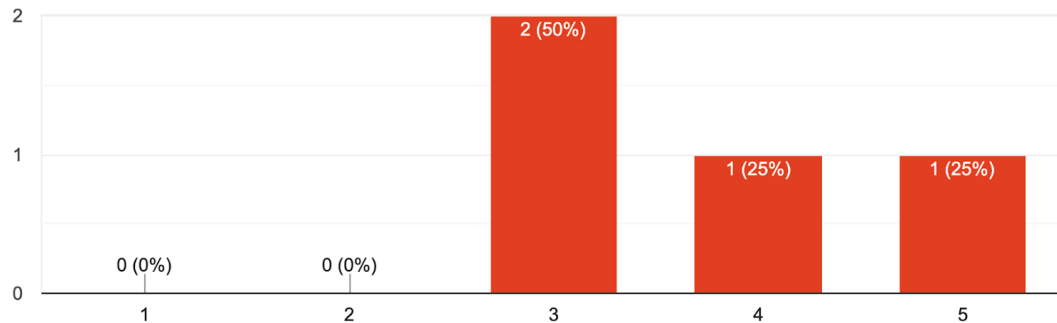
9. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, the mall. Do...st one another? Do they look out for one another?)

4 responses



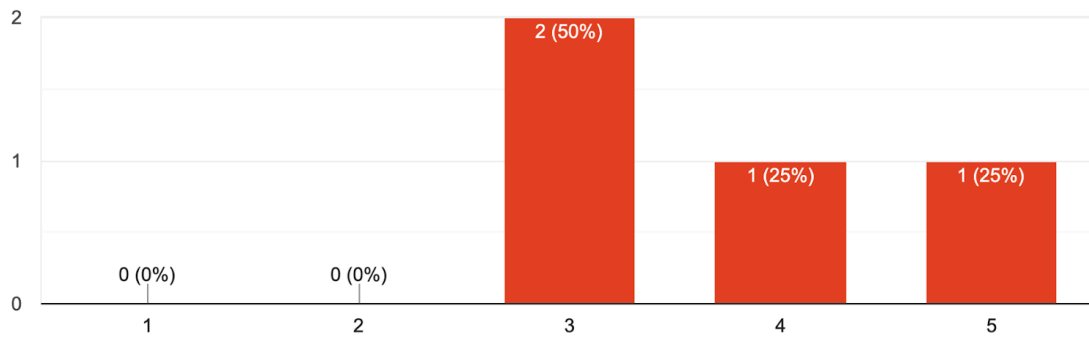
10. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, organizations) during times of stress and need?

4 responses



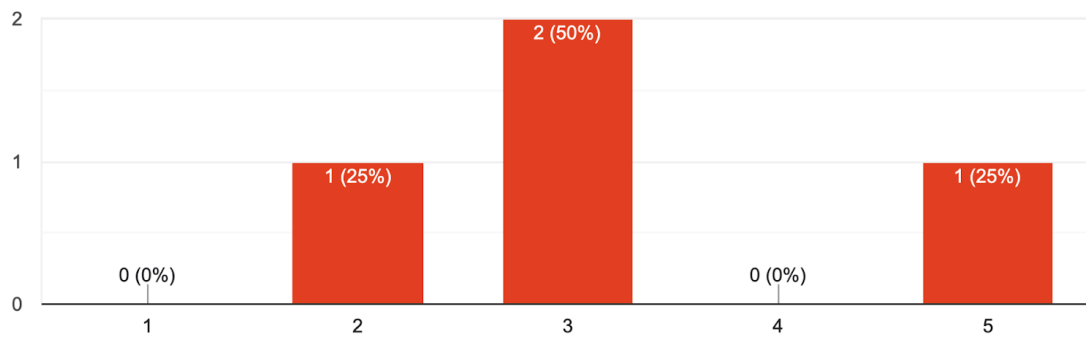
11. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?

4 responses



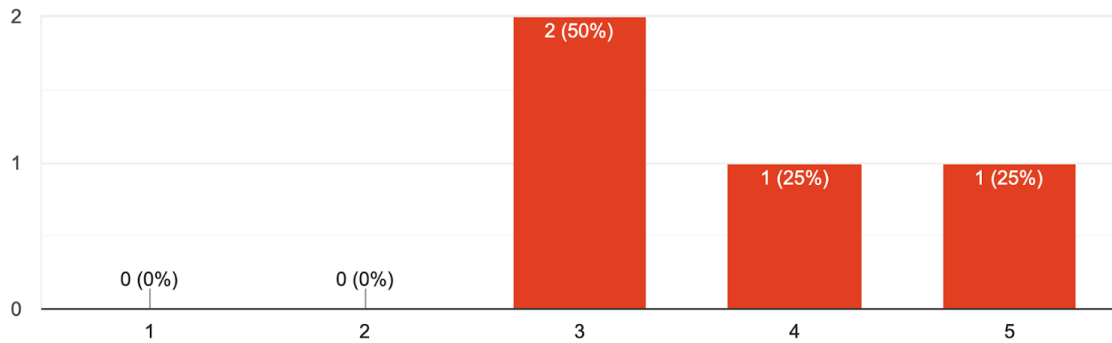
12. Do all residents perceive that they- individually and collectively- can make the community a better place to live?

4 responses



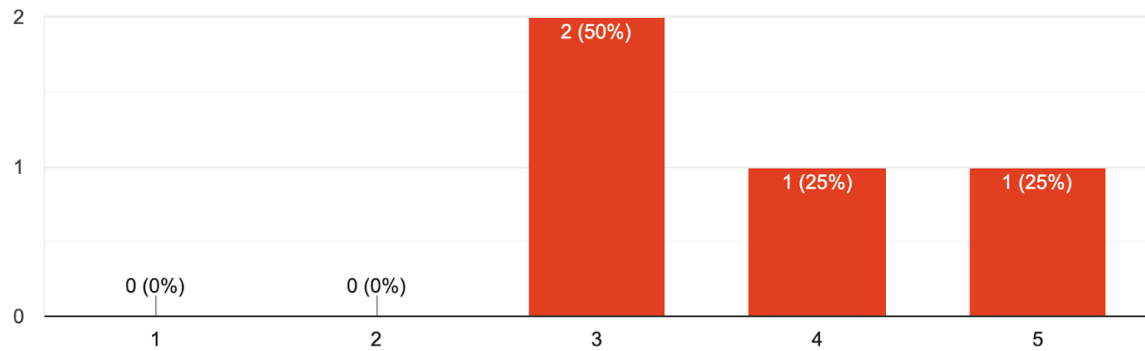
13. Are community assets broad-based and multi-sectoral?

4 responses



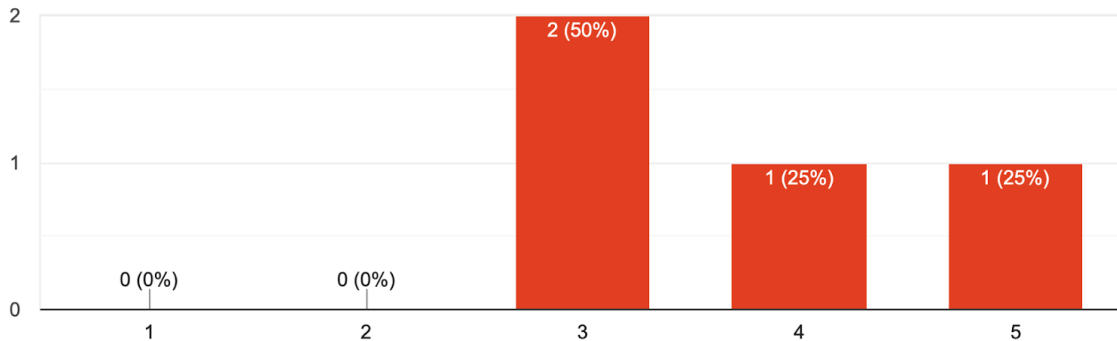
14. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?

4 responses



15. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments?

4 responses



## II. Local Public Health System Assessment

The Local Public Health System Assessment (LPHSA) focuses on the components, activities, competencies, and capacities of our local public health system. It also includes information about how the Essential Public Health Services are being provided to our community. This assessment concentrates on the entire local public health system, including all community organizations and entities that support and affect the community's health overall. The Essential Public Health Services Model has been used extensively during this assessment process.

In 1994, the Core Public Health Functions Steering Committee formed this fundamental framework (Core Public Health Functions Steering Committee, 1994). This steering committee was comprised of U.S. Public Health Service Agency members, including those from National Association of County and City Health Officials (NACCHO) and also other important public health organizations. It was determined that the list of Essential Services should be included in every community's public health activities.

**The 10 Essential Public Health Services include the following:**

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.



6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate the effectiveness, accessibility and quality of personal and population-based health services.
10. Research new insights and innovative solutions to health problems.

Various assessment mechanisms were used during this assessment procedure. The assessment mechanisms aimed to accomplish three goals. These goals included:

- A. Collect and review local residents feedback on importance of the Essential Services of Public Health;
- B. Assess our agency's capacity to provide these Essential Services;
- C. Identify core concepts of our local health department's organizational capacity, along with an analysis of potential future challenges for the department; and

Each of these assessment mechanisms and their results are crucial to the completion of this assessment and are described as follows. These assessments included extensive review of qualitative data from focus groups and online surveys to arrive at a fundamental understanding of the functioning of our public health system in Ogle County overall.

## A. Essential Public Health Services Ranked by Importance

We asked community members to rank the Essential Services of Public Health to determine which services they believed to be most important. The results are provided in Table 2 below.

**Table 2: Ogle County Resident Rankings for the 10 Essential Public Health Services**

| Ogle County Rank | 10 Essential Public Health Services                                         |
|------------------|-----------------------------------------------------------------------------|
| 9                | 1. Monitor Health Status and understand health issues facing the community. |
| 8                | 2. Protect people from health problems and health hazards.                  |
| **               | 3. Give people information they need to make healthy choices.               |
| 7                | 4. Engage the community to identify and solve health problems               |
| 6                | 5. Develop public health policies and plans.                                |
| 5                | 6. Enforce public health laws and regulations.                              |
| 3*               | 7. Help people receive health services.                                     |
| 3*               | 8. Maintain a competent public health workforce.                            |
| 2                | 9. Evaluate and improve programs and interventions                          |
| 1                | 10. Contribute to and apply the evidence base of public health              |

\*Tie Scores \*\*was not evaluated

## B. Organizational Capacity Assessment

The main responsibility of a local health department is to protect and enhance a community's health status. The capacity within an agency greatly determines its ability to provide these services. In an article by G.P. Mays, et al., it was reported that local health departments were responsible for an average 67% of total effort contributed towards the 20 public health activities (2004). Assurance activities saw 80% contribution by a local health department, 60% towards assessment activities, and 58% towards policy development tasks. All of these activities heavily relied upon the capacity of local health departments.

A local public health system assessment must include comprehensive assessments of the capacities, challenges, and strategic orientation of the local health department as well. For this assessment, the Ogle County Health Department surveyed its staff to ascertain opinions about agency strengths and weaknesses and also to provide additional information for future strategic planning purposes. For this survey, the administration used the Assessment Protocol for Excellence in Public Health (APEX-PH) model. Here, the senior management component of the Organizational Capacity Assessment team rates how important each indicator is for the successful functioning of the Health Department. This is done by assigning each indicator a rating that includes “High Importance,” “Moderate Importance,” “Low Importance,” or “Not Relevant.” The remainder of the Assessment team rates the current status of the Health Department on each indicator, rating these same indicators on the basis of “Fully met by the Health Department,” “Partially met by the Health Department,” “Not met at all by the Health Department,” or “Not Relevant.”

The process allows staff to identify strengths of the agency as those areas deemed “Highly Important” and “Fully met” and weaknesses of the agency as those “Highly Important” and “Not met at all”.

Below is the summary of responses from all staff. ALL indicators have been provided with the number of agency respondents noted in parentheses for each indicator. Those noted in blue text are highlighted as potential strengths, while those highlighted in red text are noted as potential weaknesses, perhaps indicators for further discussion:

*\*blue numbers = strengths (high importance & fully met)*

*\*red numbers = weaknesses (high importance & not met)*

*\*Yellow highlight = weakness areas of greatest concern*

#### I: Indicators for Authority to Operate

- Legal Authority
  - a. 1: The health department has clear authority to act as a law enforcement office for public health problems. (1/9)
  - b. 2: The health department has the authority to develop and introduce local regulations when needed. (2/9)
  - c. 3: The health department has the authority to delegate public health duties to municipalities within its jurisdiction. (3/9)
  - d. 4: The health department has the authority to delegate public health duties to municipalities within its jurisdiction. (3/9)
  - e. 5: The health department has exercises authorities delegated to it by the state or federal government. (5/9)
- Intergovernmental Relations

- a. 1: At least once every 2 years (biennially), the health department reviews its joint power agreements, memoranda of understanding, and other agreements with units in its jurisdiction or neighboring jurisdictions to identify problems, propose solutions, and look for areas for further development. (1/9)
- b. 3: The health department is represented on a state public health committee or other body advisory to the state health authority. (2/9)
- c. 3: The health department is represented on a state public health committee or other body advisory to the state health authority. (4/9)
- d. 4: Units of government within the jurisdiction of the health department are represented on a committee, sub-committee, or other body advisory to the local department of health. (1/9)
- e. 5: The health department is regularly consulted by the local elected officials about aspects of local policy relating to health issues. (2/9)
- f. 6: The health department is regularly consulted by the state elected officials about aspects of local policy relating to health issues. (1/9)
- g. 7: The administrator or a representative communicates appropriately and regularly with the state legislators who represent the district the health department serves. (1/9)
- h. 8: The health department is regularly consulted by the local schools when setting health policy. (2/9)
- i. 9: The health department has a formal and productive working relationship with the state health authority. (3/9)
- Legal Counsel
  - a. 1: The health department has legal counsel sufficient to provide advice as needed on administrative practices; department powers, duties, policies and procedures; relevant laws and ordinances; contracts; and other legal matters. (1/9)
  - b. 1: The health department has legal counsel sufficient to provide advice as needed on administrative practices; department powers, duties, policies and procedures; relevant laws and ordinances; contracts; and other legal matters. (2/9)
  - c. 2: The health department maintains a current file or library of all relevant federal, state, and local statutes and regulations. (2/9)
  - d. 5: The health department maintains current files documenting the legal status of all health-related organizations operating within its jurisdiction (department of government, private non-profit corporation, private unaffiliated and unincorporated groups, ect.). (1/9)

## II: Indicators for Community Relations

- Constituency Development
  - a. 1: The health department has a system that actively involves individuals and groups affected by its planning of service. Its methods of service delivery, and its service results. (1/9)

- b. 2c: Interest groups, such as environmental protection and conservation groups, local business organizations, and other key organizations in the community. (1/9)
- c. 3: The health department cooperates and collaborates with other community agencies that have similar or overlapping missions. (3/9)
- d. 4: The health department cooperates and collaborates with other agencies that deliver similar programs in the same service area. (5/9)
- e. 5: The health department has formed a citizens' or community committee or has established another formal method of involving the people it serves in the identification of community health problems and the development of a community health plan. (2/9)
- f. 7: Health department staff are aware of relevant programs, policies, and priorities of the federal Department of Health and Human Service (HHS), Environmental Protection Agency (EPA), and other related federal agencies. (1/9)
- g. 8: The health department has a physician health officer, medical advisor(s), or consultant(s) to assist in maintaining relationships with the private medical community. (3/9)
- h. 8: The health department has a physician health officer, medical advisor(s), or consultant(s) to assist in maintaining relationships with the private medical community. (1/9)
- Constituency Education
  - a. 1: The health department has a documented plan for informing the public about the current health status of the community. (2/9)
  - b. 2: The local media looks to the health department as a source of information about the health of the community. (4/9)
  - c. 3: The health department regularly provides background information and news information on local media. (4/9)
  - d. 4: At least once per year, the administrator or a representative of the administrator meets with the representatives of health-related community organizations to define inter-organizational roles and responsibilities (see item A2 above for a brief list of representatives). (1/9)
  - e. 5: Professional staff members of the health department participate in or serve on councils, boards, or committees, of public-health related organizations at the state and local levels. (2/9)
  - f. 6: The health department has current mailing lists (no older than 1 year) of the directors, chairs, or other officials of all citizen groups, service organizations, healthcare professional organizations, business groups, and other community organizations within its jurisdiction. (1/9)
  - g. 7: The health department has a means of regular public communication; such as a regular newsletter or column in a community newspaper. (3/9)

- h. 7: The health department has a means of regular public communication; such as a regular newsletter or column in a community newspaper. (1/9)

- Documentation

- a. 1: The health department maintains files documenting relations and communications with other organizations related to public health. (2/9)

### III: Indicators for Community Health Assessment

- Mission and Roles

- a. 1: The health department has a clear and concrete mission statement that all staff are capable of stating and explaining in relation to their duties. (6/9)
- b. 2: The health department has established a process for community health assessment and the development of a community health plan. (4/9)
- c. 3: At least every four years, the health department conducts a public review and discussion of its mission and role, its public health goals, its accomplishments, past activities, and plans in relation to community health. (3/9)
- d. 4: At least every two years, the health department formally requests all units of government within its jurisdiction to comment on the department's programs, plan, and budget. (1/9)
- e. 6: The health department maintains a current description (no older than two years) of the public health services, programs, and authorities of the municipalities in its jurisdiction. (2/9)

- Data Collection and Analysis

- a. 1: The health department maintains a database of existing health resources and community health status. (1/9)
- b. 2: The health department receives reports of communicable diseases in the community on a daily basis. (9/9)
- c. 3: The health department has qualified professionals to review and analyze reported morbidity and mortality data. (3/9)
- d. 3: The health department has qualified professionals to review and analyze reported morbidity and mortality data. (1/9)
- e. 4: Morbidity and mortality data are reviewed and analyzed for appropriate action on a regular schedule. (1/9)
- f. 4: Morbidity and mortality data are reviewed and analyzed for appropriate action on a regular schedule. (1/9)
- g. 8: The health department regularly collects or requests and receives from the state health authority locally specific data needed for assessing the health of the community. (1/9)

- Resource Assessment

- a. 2: The health department maintains a current roster of qualified health professional employed by units of government within its jurisdiction for reference

- in the development of technical study groups, activities related to professional development, and other personnel-related purpose. (1/9)
- b. 3: The health department participates in joint efforts to pool training needs with neighboring health agencies. (2/9)
- c. 3: The health department participates in joint efforts to pool training needs with neighboring health agencies. (1/9)
- d. 4: The health department has agreements with health-related organization operating programs within its jurisdiction for sharing staff expertise. (2/9)
- e. 6: The health department has an established program for the development of in-kind contributions from private industry, private non-profit organizations, churches, and other community organizations. (1/9)
- Planning and Development
  - a. 1: The health department has staff with education and experience in planning and evaluation. (4/9)
  - b. 2: The health department used health data, including vital records, in its community health planning process. (3/9)
  - c. 3: The health department has a standard, ongoing process to examine internal and external trends, to make forecasts, and to systematically develop long term plans for its future. (1/9)
  - d. 4: The health department has a published strategic plan that includes the current year. (3/9)
- Evaluation and Assurance
  - a. 1: The health department monitors program impact indicators on a regular basis. (2/9)
  - b. 2: The health department has community health objectives that are time limited and measurable. (1/9)

#### IV: Indicators for Public Policy Development

- Community Health Assessment and Planning
  - a. 1: The health department administrator assures and facilitates the completion of a community health assessment process. (1/9)
  - b. 2: The health department and the community identify and set priorities for addressing health problems based on the results of the community health. (1/9)
  - c. 4: The health department administrator and the community involve the Board of Health in the review and revision, if necessary, of the proposed community health plan. (2/9)
  - d. 5: The Board of Health adopts the community health plan. (2/9)
  - e. 6: The Board of Health acts as an advocate on behalf of the health department for allocation of resources needed to implement the community health plan. (1/9)
  - f. 6: The Board of Health acts as an advocate on behalf of the health department for allocation of resources needed to implement the community health plan. (1/9)

- g. 7: The Board of Health monitors the implementation of the community health plan. (1/9)
- Community Health Policy
  - a. 1: The Board of Health obtains information from an established citizens' advisory group and from the health department regarding public policy issues affecting the public health. (1/9)
  - b. 4: The health department facilitates the formulation of public health policy in the community. (1/9)
- Public Policy and Public Health Issues
  - a. 1: The local government unit collaborates with the Board of Health and the health department administrator in developing public policy which may impact public health. (2/9)
  - b. 2: The elected officials at the local level actively solicit the opinions of the professional staff and/or the health department administrator on scientific issues in policy development. (3/9)
  - c. 3: The health department administrator and the Board of Health participate at both the state and local levels in governmental decision making which may have an impact on local health issues. (1/9)

#### V: Indicators for Assurance of Public Health Services

- Public Policy Implementation
  - a. 1: The Board of Health uses its authority to assure necessary service to reach agreed upon goals for its constituents. (1/9)
  - b. 2: The Board of Health assists the health department in utilizing all resources in the community to assure the desired services to all its citizens. (1/9)
  - c. 4: The health department assures and implements legislative mandates and statutory responsibilities. (1/9)
  - d. 5: The health department maintains a level of service without interruption to avoid crisis affecting the health of the community. (4/9)
- Personal Health Services
  - a. 1: The health department monitors the availability of personal health service and assures an appropriate level of those health services in the community. (1/9)
  - b. 1: The health department monitors the availability of personal health service and assures an appropriate level of those health services in the community. (1/9)
  - c. 2: The health department seeks to assure that all citizens receive the level of personal health services referred to in B1, above, regardless of their ability to pay. (3/9)
  - d. 2: The health department seeks to assure that all citizens receive the level of personal health services referred to in B1, above, regardless of their ability to pay. (1/9)



- e. 3: The health department identifies barriers to access to health care and develops plans to minimize the. (1/9)
- f. 4: The health department provides the services necessary to assure a clean, safe, and secure environment for the community. (5/9)
- Involvement of Community in the Public Health Delivery System
  - a. 1: The Board of Health and the senior management of the health department will work with employee groups in assessing health risks of employees and in managing those risks. (1/9)
  - b. 3: The Board of Health and the health department administrator assure health protection and health promotion services utilizing community-based organizations. (1/9)

#### VI: Indicators for Financial Management

- Budget Development and Authorization
  - a. 1: A department budget is adopted annually by the Board of Health. (5/9)
  - b. 2: The budget accurately reflects the priorities established in the organizational action plan. (2/9)
  - c. 3: Budget justifications reflect health department programs and health programs within its jurisdiction. (1/9)
  - d. 5: Health department management staff are involved in developing the proposed budget (2/9).
  - e. 6: The health department receives locally assessed tax funds from the unit of government to which it is responsible. (1/9)
  - f. 7: The health department has the authority to recommend and charge fees for the services it provides. (7/9)
  - g. 8: The health department has an adequate contingency fund for dealing with public health emergencies. (2/9)
- Financial Planning and Financial Resource Development
  - a. 1: The health department has a predictable source of funds to allow the development and implementation of a long range plan (minimum, 5 years). (2/9)
  - b. 2: The health department has a financial management capacity that provides for securing funding for, or the orderly phasing out of, discretionary programs for which funds are not available. (1/9)
  - c. 3: The health department has a diverse funding base to lessen disruption of services caused by withdrawal of funds from any one source. (1/9)
  - d. 3: The health department has a diverse funding base to lessen disruption of services caused by withdrawal of funds from any one source. (1/9)
  - e. 5: The health department has a current description of state and federal funding sources available to it and to organizations within its jurisdiction. (1/9)
  - f. 6: The health department maintains current information on the health-related budgets and expenditures of all units of government within its jurisdiction. (2/9)

- g. 7: The health department has staff skilled in writing successful grant applications. (5/9)
- h. 8: The health department has agreements with units of government within its jurisdiction that allows the use of local expenditures to be documented as "match" in its grant requests. (1/9)
- i. 9: The health department has contracts to provide public health services to or for community organization, private non-profit corporations, and health care organizations. (1/9)
- Financial Reporting and Administration
  - a. 1: Expenditures follow the budget and financial plan of the health department. (2/9)
  - b. 4: The financial position of the health department is routinely reviewed by the Board of Health and administrative and supervisory staff. (3/9)
  - c. 5: An administrative office or finance director is designated by the Board of Health to oversee all finances of the health department, including meeting all legal financial requirements, adherence to department fiscal policies, and reporting to the Board of Health regularly on financial matters. (2/9)
  - d. 6: The Board of Health and staff understand their legal accountability and liability, as well as their general responsibility to the public for wise financial management. (2/9)
- Audit
  - a. 1: The health department has an independent, outside, annual financial and performance audit which conforms with requirements stipulated by general accounting principles. (3/9)
  - b. 2: The annual audit is reviewed and clearly understood by the Board of Health and key department staff. (1/9)
- Documentation
  - a. 1: A written standard budget development and review procedure is authorized by the Board of Health, and is available to staff and the public. (2/9)
  - b. 1: A written standard budget development and review procedure is authorized by the Board of Health, and is available to staff and the public. (1/9)
  - c. 2: Appropriate journals, ledgers, registers, and financial reports are kept, using generally accepted accounting procedures. (2/9)
  - d. 3: Copies of the health department annual financial audit are available to Board of Health members, department staff, and the public. (3/9)
  - e. 3: Copies of the health department annual financial audit are available to Board of Health members, department staff, and the public. (1/9)
  - f. 4: A written procedure for participating in state and federal grants, and public and private foundation funding awards, is authorized by the Board of Health and available to department staff and the public. (1/9)

## VII: Indicators for Personnel Management

- Policy Development and Authorization
  - a. 1: A written job description, including minimum qualifications, exists for each position in the health department. (6/9)
  - b. 2: Written personnel policies and procedures are developed or revised with staff input. (6/9)
  - c. 3: Personnel recruitment, selection, and appointment procedures are documented. (4/9)
  - d. 6: Both the Board of Health and senior management of the health department have input into any labor contract negotiations. (1/9)
  - e. 7: There is a documented procedure, authorized by the Board of Health and developed with the input from senior management of the health department and staff where appropriate, for employee grievances, reprimands, suspensions, and dismissals. (5/9)
  - f. 8: There is a documented, structured salary administration plan that is authorized by the Board of Health and this is designed to attract and retain competent staff. (4/9)
- Personnel Administration and Reporting
  - a. 1: The health department administrator is responsible for internal administration of the department. (6/9)
  - b. 2: Board of Health employs the health department administrator and conducts a periodic, written appraisal of the administrator's performance. (2/9)
  - c. 3: Written staff performance appraisals are conducted by managers with employees at established intervals. (5/9)
  - d. 4: The performance appraisal system is monitored by the health department administrator. (4/9)
  - e. 6: Health department announcements and program information are distributed to all employees via a standard mechanism. (2/9)
  - f. 6: Health department announcements and program information are distributed to all employees via a standard mechanism. (1/9)
  - g. 7: There are regularly scheduled meetings by work group, work site, division, and department. (7/9)
  - h. 8: The Board of Health receives routine reports from the health department administrator relative to new employees, staffing changes, dismissals, grievances, etc. (3/9)
  - i. 9: The health department administrator selects qualified individuals as staff for the department. (7/9)
  - j. 10: The health department provides appropriate confidentiality for all personnel records. (6/9)
- Staffing Plan and Development

- a. 1: Staffing patterns and levels match Board of Health authorized programs and services and current levels of demand for services. (4/9)
- b. 2: The health department has a written plan or policy regarding staff recruitment, selection, development, and retention. (2/9)
- c. 3: All employees have structured, routine, group opportunities to discuss program methods and procedures, current levels of demand for services, and quality of work issues with their respective supervisors. (5/9)
- d. 4: The health department staff have access to training provided by the state health authority in areas relevant to local health problems. (7/9)
- e. 5: The health department has access to the staff development resources of a school of public health or of other educational institutes. (4/9)
- f. 6: The health department has clearly expressed its staff development needs to schools of public health or to other educational institutions. (1/9)
- g. 7: The health department uses volunteers to support programs where possible, and manages its volunteer program through clearly defined policies and procedures. (1/9)
- h. 7: The health department uses volunteers to support programs where possible, and manages its volunteer program through clearly defined policies and procedures. (2/9)
- i. 8: There are adequate provisions for liability insurance protection for department board meetings, staff, and volunteers. (1/9)
- j. 9: The health department has a documented staff development program, monitored by the administrator, which includes employee-supervisor annual plan development and cost projections, with routine review and update. (1/9)
- k. 11: The health department encourages and supports staff participation in professional organizations. (2/9)
- l. 12: The health department staffing plan includes provisions for "backup staff" to enable critical scheduled operations to continue without interruption when temporary vacancies occur. (1/9)
- m. 13: The health department has the ability to fill new and vacant positions in a timely manner. (6/9)
- Personnel Policy and Procedure Audit
  - a. 3: There is a written, standard employee exit interview conducted with every employee leaving the health department, which includes identification of reasons for resignation. (1/9)
  - b. 4: The health department administrator monitors all employee exit interview results, and periodically reports such information to the Board of Health. (1/9)
- Documentation

- a. 1: There is a standard, written description of the health department personnel management system which is available to Board of Health members, department staff, and the public. (2/9)
- b. 2: All personnel transactions are documented. (2/9)
- c. 3: An up-to-date coordinated, structured, and confidential file is maintained for every employee and volunteer. (1/9)
- d. 4: All job descriptions, policies, and procedures are consolidated and available to Board of Health members, department staff, and the public. (2/9)
- e. 6: The salary administration plan is written and available to Board of Health members, department staff, and the public. (1/9)

#### VIII: Indicators for Program Management

- Organizational Structure
  - a. 1: Operating programs are authorized by the Board of Health. (3/9)
  - b. 2: The administrator regularly reviews and discusses with the health department's management team the perceived roles and authorities of units of government within its jurisdiction. (1/9)
  - c. 3: There is a current organizational chart which shows all functional elements of the organization and their relationship to each other. (1/9)
  - d. 4: Staff meetings are held at reasonable frequencies, include appropriate staff, and are called and structured by appropriate individuals. (6/9)
  - e. 5: The health department maintains emergency contact staff (on site or on call) to respond to local public health emergencies. (6/9)
- Evaluation
  - a. 1: The health department collects and regularly analyzes information describing program administration and funding, program activities, workload, client characteristics, and service costs needed to evaluate the process of program activities. (2/9)
  - b. 2: The health department collects and regularly analyzes information that is needed to evaluate the impact and outcome of program activities on risk factors and health status. (1/9)
  - c. 5: The health department routinely examines the working environment to ensure that it facilitates program objectives and that the physical plant is "barrier free" and meets state and local building standards. (1/9)
- General Information Systems
  - a. 4: The health department annually compiles or updates a listing of health-related information systems and data bases maintained by units of government within its jurisdiction. (1/9)
  - b. 5: The health department subscribes to an on-line computer-based data system that provides direct access to health-related data or that has direct access to public health and population data compiled by state agencies. (4/9)

- c. 6: The health department maintains current information on federal data bases and information systems relevant to its program. (1/9)
- Shared Resources
  - a. 1: The health department has formal or informal agreements with other units of government within or surrounding its jurisdiction for sharing expense, less-used equipment (e.g. mainframe computer systems). (1/9)
  - b. 2: The health department participates in shared service or purchase agreements where volume purchasing can reduce costs, such as for printing, supplies, and other materials. (1/9)
  - c. 3: The health department has agreements with community organizations for sharing space, clerical support, and other resources. (1/9)
  - d. 3: The health department has agreements with community organizations for sharing space, clerical support, and other resources. (1/9)

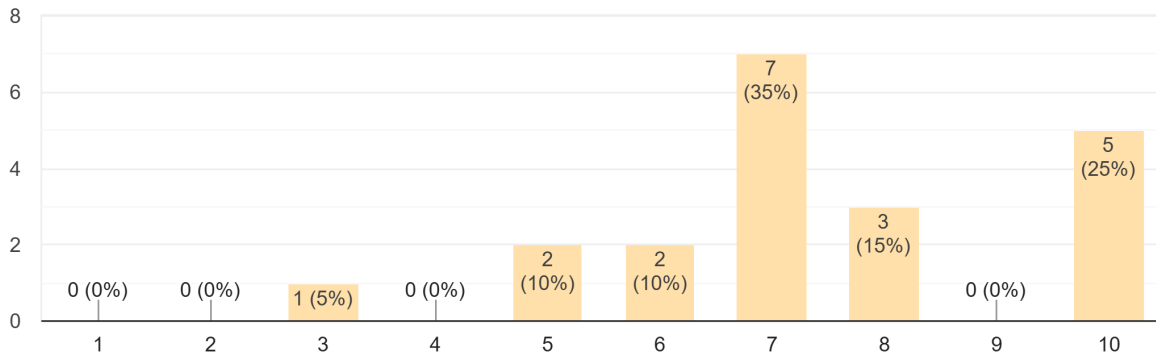
#### IX: Indicators for Board of Health Procedures

- 1: Health department's Board of Health board members attend Board of Health and committee meetings. (3/9)
- 3: Board of Health meetings are scheduled on a regular basis, with sufficient frequency to ensure board control and direction of the health department. (3/9)
- 4: Board of Health materials, including agenda and study documents, are mailed to members no less than 3 days in advance of board meetings. (1/9)
- 5: Board of Health meetings deal primarily with policy determination, review of plans, making board authorizations, and evaluating the work of the health department. (2/9)
- 7: The health department publishes the schedule of regular policy Board of Health meetings in the local news media. (1/9)
- 7: The health department publishes the schedule of regular policy Board of Health meetings in the local news media. (1/9)
- 8: Minutes of the Board of Health and committee meetings are written and circulated to Board of Health members and the health department staff, and are available to the public. (2/9)
- 8: Minutes of the Board of Health and committee meetings are written and circulated to Board of Health members and the health department staff, and are available to the public. (1/9)

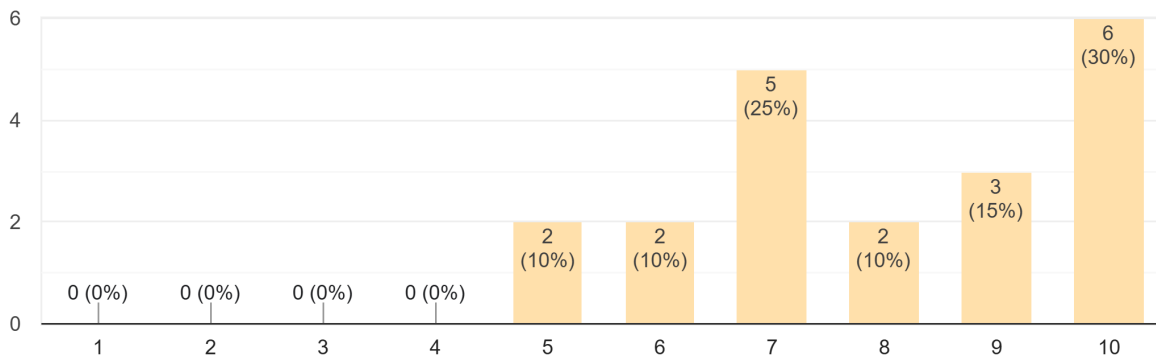
Also, students enrolled in the HLTH 240: Foundations of Health Education/Health Promotion did an additional survey of staff members that was based around a survey used in social service agencies. This survey instrument was extensive and included 133 questions around multiple domains including: Project Implementation, Monitoring and Evaluation/Quality Assurance, Staffing, Job Descriptions/Staff Supervision, Volunteers and Interns, Vision and Mission/Values, Governing/Advisory Board, Succession Planning, Operational Policies/Procedures/Systems, Strategic and Operational Plan, Resource Mobilization, Communication Strategy, Stakeholder Involvement, Advocacy Planning, Engaging Target Populations in Advocacy and Marketing, Program Management, and Financial Management. There were 13 responses overall and the results are located in the Appendices. However, 20 staff

reviewed the Ten Essential Services of Public Health in this survey and provided feedback on a scale of 1 to 10 how well they believed each service was fully met (with 1 being Not Met at All). Results are noted below:

89. Monitor Health Status to identify community health problems: This includes obtaining/maintaining data on the community's heal...and developing relationships with local providers  
20 responses

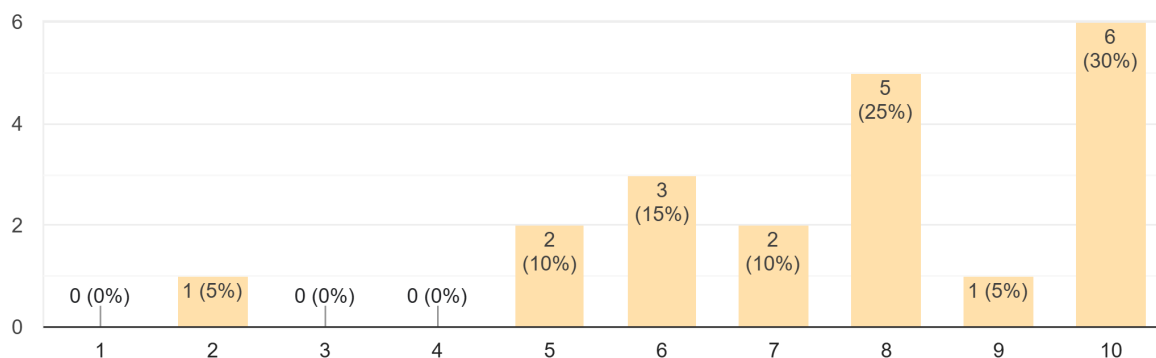


90. Diagnose and investigate health problems and health hazards in the community: This includes investigation of health and environmental problem...sses, as well as emergency planning and response.  
20 responses



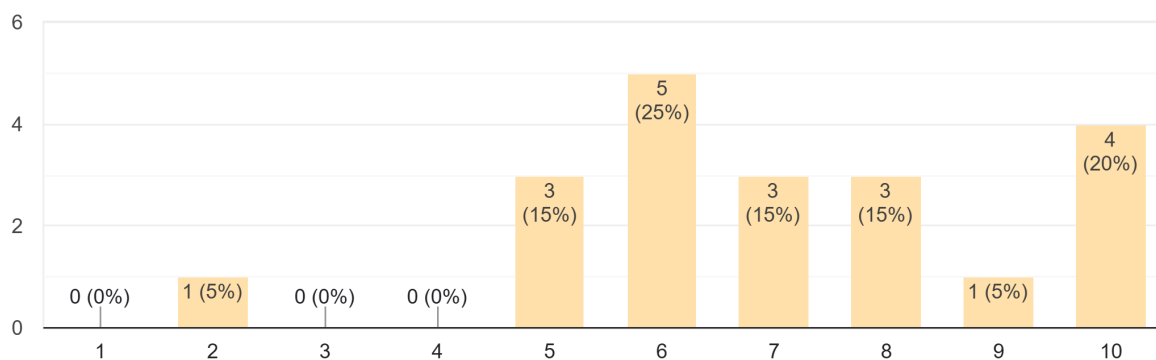
91. Inform, educate, and empower people about health issues: This includes providing information to the media, individuals, community groups, etc., and the provision of health promotion programs.

20 responses



92. Mobilize community partnerships to identify and solve health problems: Includes developing partnerships to generate interest in and support for community health status.

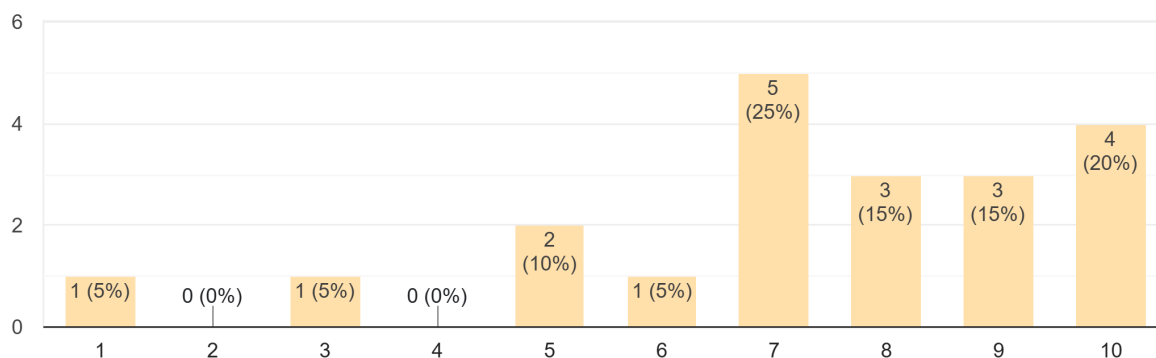
20 responses





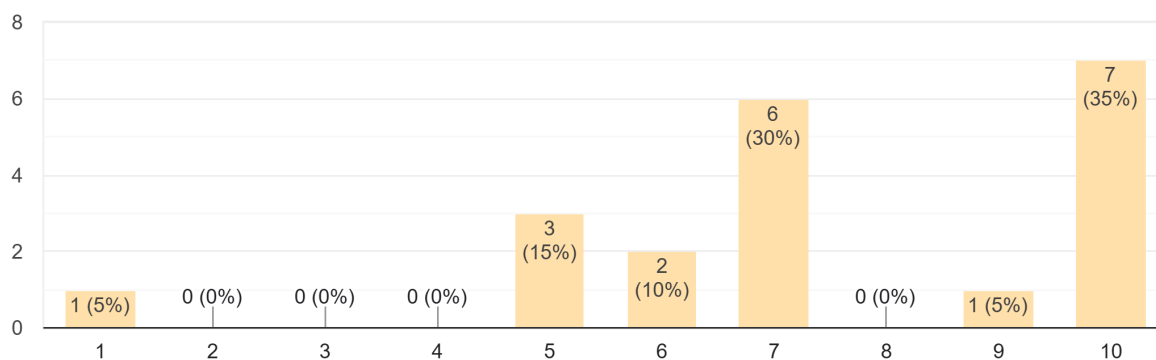
93. Develop policies and plans that support individual and community health efforts: Includes advocacy for policies that lesson health disparities ...ns in the community that affect the public's health.

20 responses



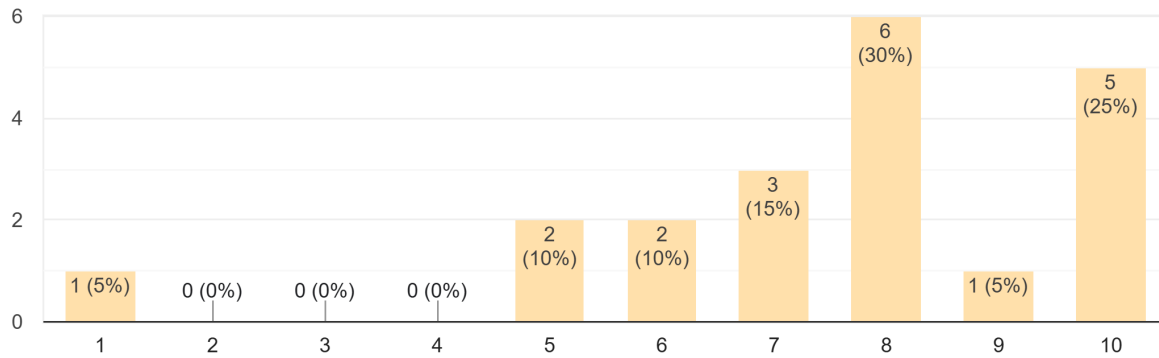
94. Enforce laws and regulations that protect health and ensure safety: Understand, review, update, and enforce ordinances and/or laws, which protect the public's health.

20 responses



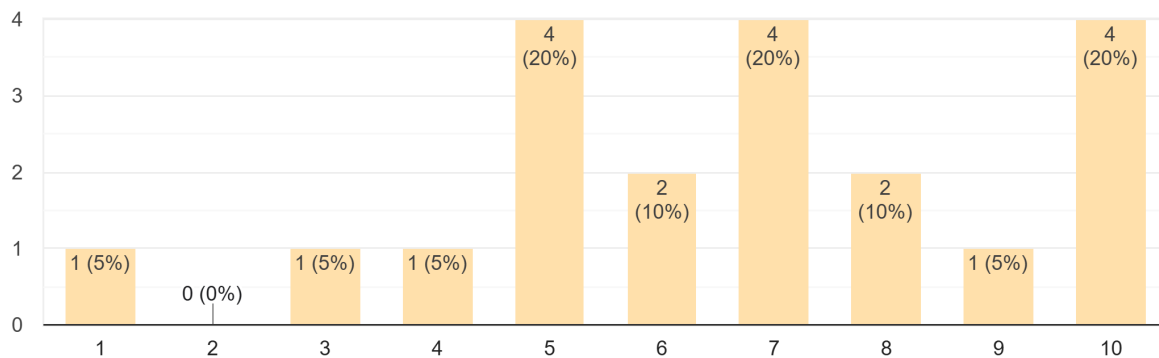
94. Assure a competent public health and person health care workforce: Recruit, train, develop, and retain staff with diverse public health expertise.

20 responses



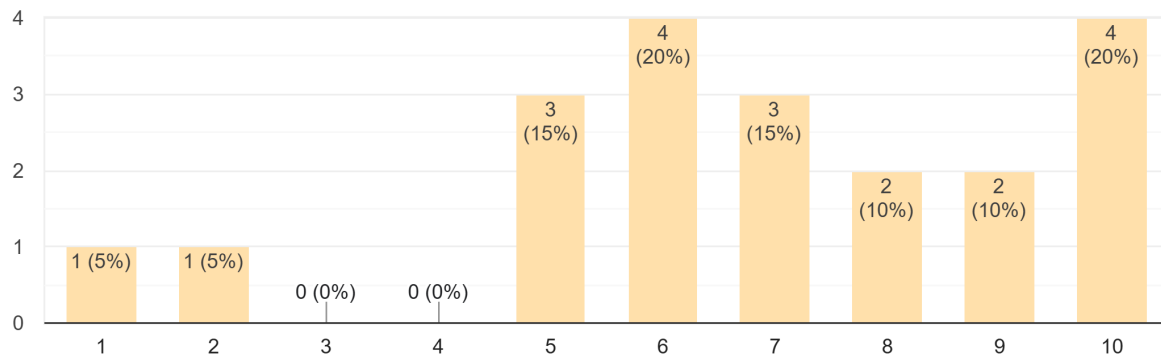
96. Research for new insights and innovative solutions to health problems: Participate in areas of research that benefit the health of the community ...ence-based findings to programs and/or practices.

20 responses



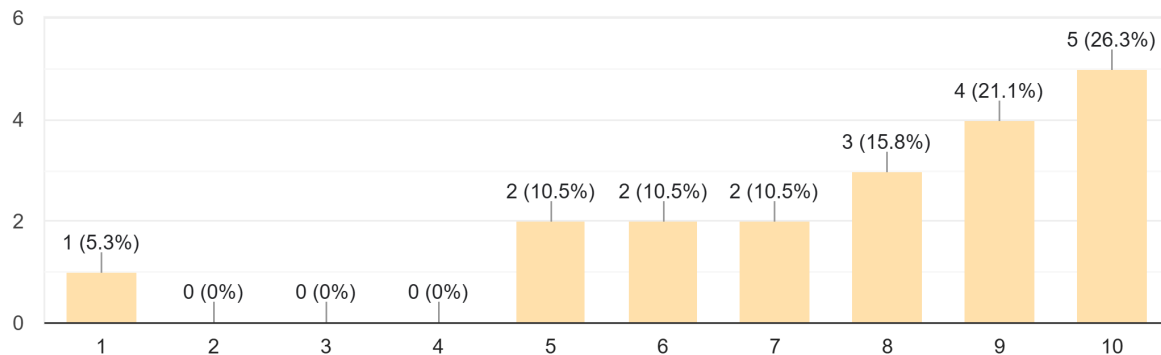
97. Evaluate effectiveness, accessibility, and quality of personal and population-based health services: Includes the evaluation of the effective...s, and implementation of any needed improvements.

20 responses



98. Link people to needed personal health services and assure the provision of health care when otherwise unavailable: Including individuals to avail...rs and identifying gaps in personal health services.

19 responses



## C. System Analysis

Additionally, questions were asked in our local community survey that we viewed as critical to understanding how our local public health system operates overall. These questions and responses are noted below:

**Q:** *Do you have a primary care provider?*

Yes 95.88% (186)

No 4.12% (8)

***Q: If you have a primary care provider, have you seen them within the last year?***

|                |              |
|----------------|--------------|
| Yes            | 92.19% (177) |
| No             | 5.21% (10)   |
| Not applicable | 2.60% (5)    |

***Q: Where do you usually go when you are sick or need healthcare?***

|                                                            |              |
|------------------------------------------------------------|--------------|
| Primary care provider                                      | 77.84% (151) |
| Urgent care/immediate care clinic                          | 17.50% (34)  |
| Hospital emergency department                              | 2.06% (4)    |
| Depends on illness & availability of primary care provider | 0.52% (1)    |
| Free clinic in Chicago                                     | 0.52% (1)    |
| IBEW clinic                                                | 0.52% (1)    |
| Cruceiros                                                  | 0.52% (1)    |
| Integrative doctor                                         | 0.52% (1)    |

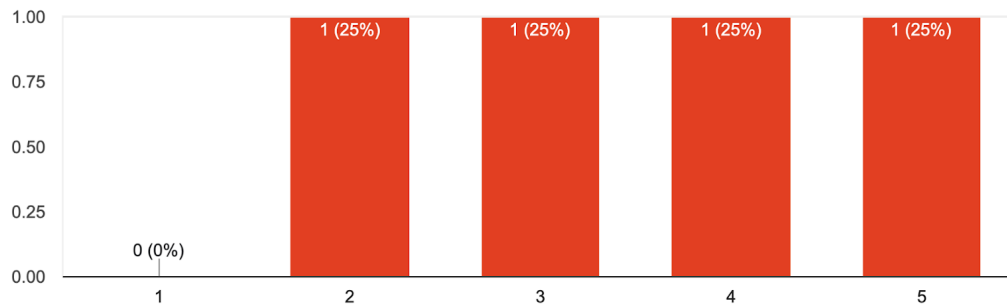
***Q: How do you pay for your healthcare?***

|                                                                |              |
|----------------------------------------------------------------|--------------|
| Private health insurance (employer provided or self-purchased) | 66.15% (127) |
| Medicare                                                       | 22.92% (44)  |
| Medicaid                                                       | 5.73% (11)   |
| Pay cash/no insurance                                          | 3.13% (6)    |
| Medicare disability                                            | 0.52% (1)    |
| Obama care                                                     | 0.52% (1)    |
| Veteran's Administration (VA)                                  | 0.52% (1)    |

Although response rates in this last question were especially low, indications are that feelings toward the health care system range considerably.

5. Are you satisfied with the health care system in the community? (Consider school quality, day care, after school programs, recreation, etc.)

4 responses



### III. Community Health Status Assessment

The Community Health Status Assessment is critical for understanding the health concerns and needs of the community. Through this assessment, it is possible to understand the community's health status as a whole, with a strong portrayal provided from collected quantitative data. It is also an essential component of the MAPP process. Noted in the MAPP guidance, "this stage provides detailed information about specific health issues that the community is facing (e.g. high rates of heart disease or low numbers of community members with health insurance). These foundational data are collected from a number of different sources, and are subsequently analyzed to identify community health issues. These data are then compared with state data to determine differences in health status across the different levels. This activity is primarily lead by local health departments, as they have the core capacity to lead. The bulk of data collection is often completed by a few smaller organizations, but including community perspective is also crucial for this assessment, as it provides qualitative information about health status within the community."

The National Association of County and City Health Officials (NACCHO) split this assessment into six different steps. These steps include:

#### Step 1- Prepare for the Community Health Status Assessment

This assessment typically requires a subcommittee to oversee the tasks involved in this component of the MAPP process. The subcommittee would also be responsible for overseeing all related activities. Representation on such a subcommittee is not restricted to business leaders or heads of organizations, but rather various representatives from diverse backgrounds across the

community. This diversity provides important perspective for the committee. The Ogle County Health Department relied heavily on local hospital leadership to pull together this subcommittee and provide the resources needed to assist with this process. These resources included staffing, the computer hardware and software that was used to collect and analyze data, and resources for copying and printing materials used throughout the assessment process.

## **Step 2 – Collect data for the core indicators on the CHSA indicator list**

Being often an arduous task, data collection was somewhat simplified at this step because the health department provided the subcommittee with any available data from IDPH and other government sources. It's crucial to analyze data trends and be able to compare time-varying data. This helps in determining if any trends have increased or decreased over time, and provides the opportunity to compare data across communities and over time. These data were also compared to state data over time.

## **Step 3 – Identify locally-appropriate indicators and collect the data**

Various other indicators are also crucial for understanding the health status of a community. For this portion of the assessment process, these additional datasets and assessments were reviewed and analyzed:

- IPLAN Data System
- Behavioral Risk Factor Surveillance System
- County Health Rankings
- Rochelle Community Hospital Community Health Needs Assessment
- Ogle County Health Department Survey

## **Step 4 – Organize and analyze the data; develop a compilation of the findings; and disseminate the information**

After collecting the various data and assessments, Dr. Remmert, project consultant, provided review of the qualitative and quantitative data collected and summarized the findings.

Comparisons were made with state data to highlight any issues or concerns within the community's health status. A specific spreadsheet located in the Appendix was created for the County Health Ranking data to understand health trends impacting Ogle County over time.

## **Step 5 – Establish a system to monitor the indicators over time**

This data has been continually collected and updated, and will continue to be monitored over time. This ongoing observation will help aid in following trending health concerns for years to come. The local health department, or one other comparative entity should take the lead in managing and reviewing the data for any consequential changes.

## Step 6 – Identify challenges and opportunities related to health status

This phase in the assessment provides a list of important influencing factors for the community's health status overall. This data was critical for understanding the health concerns within our county jurisdiction. All data were examined and analyzed to identify any challenges to the community's health status. Opportunities to improve health status within the community were also derived from these data analyses. Health related risk and any contributing factors were also determined using this data. All data was updated and compared to previously collected data, spanning time and geographic location.

### *Significant Findings*

The intent of this assessment is to present specific information that describes the health of the population of Ogle County. This data comes in both qualitative (opinions and feedback of residents) and quantitative forms to help us determine specific health concerns facing our community. Project staff reviewed the IPLAN data system, the Behavioral Risk Factor Surveillance System, the County Health Rankings Report, along with local survey/focus group results to better understand health issues of concern to Ogle County. In order to get a clear snapshot of health in Ogle County, some of the most important data is presented below:

***Q: What do you think are the 3 most important health CONCERNS in Ogle County? Please select only 3:***

|                                                            |              |
|------------------------------------------------------------|--------------|
| Alcohol/drug abuse                                         | 42.05% (82)  |
| Mental Health (depression, anxiety, etc.)                  | 55.38% (108) |
| Aging problems (e.g. arthritis, hearing/vision loss, etc.) | 18.46% (36)  |
| Obesity and Overweight                                     | 19.49% (38)  |
| Bullying                                                   | 16.92% (33)  |
| Cancers                                                    | 12.31% (24)  |
| Child Abuse/Neglect                                        | 13.85% (27)  |
| Domestic Violence                                          | 18.97% (37)  |
| Diabetes                                                   | 5.64% (11)   |
| Housing that is safe and affordable                        | 22.56% (44)  |
| Too much screen time/technology use                        | 14.36% (28)  |
| Heart Disease and Stroke                                   | 5.13% (10)   |
| Tobacco Use/Smoking/E-Cigarettes                           | 7.69% (15)   |

|                                                         |            |
|---------------------------------------------------------|------------|
| Dental problems                                         | 5.13% (10) |
| Disabilities (e.g. physical development, sensory, etc.) | 4.62% (9)  |
| Stress                                                  | 8.21% (16) |
| Motor Vehicle Injury                                    | 5.13% (10) |
| Violence                                                | 1.54% (3)  |
| Suicide                                                 | 3.59% (7)  |
| High Blood Pressure                                     | 2.56% (5)  |
| Accidental injuries                                     | 2.05% (4)  |
| Unplanned Pregnancy                                     | 1.54% (3)  |
| Infectious Disease (e.g. flu, TB, Hepatitis, etc.)      | 1.54% (3)  |
| Rape/Sexual Assault                                     | 1.03% (2)  |
| Sexually Transmitted Infections                         | 1.03% (2)  |
| Teen Pregnancy                                          | 1.03% (2)  |
| Not having a urgent/immediate care in the area          | 0.51% (1)  |
| Too many bars                                           | 0.51% (1)  |
| Dementia                                                | 0.51% (1)  |
| Not enough jobs for 16-20 year olds                     | 0.51% (1)  |
| Communication                                           | 0.51% (1)  |

***Q: What are the top 3 “risky behaviors” in Ogle County? Please select only 3:***

|                                                              |              |
|--------------------------------------------------------------|--------------|
| Alcohol/Drug Abuse                                           | 71.13% (138) |
| Tobacco Use/Smoking/E-Cigarettes                             | 28.87% (56)  |
| Being Overweight                                             | 31.96% (62)  |
| Poor Nutrition/Eating Habits                                 | 38.02% (73)  |
| Lack of Car Safety (e.g. car seats/seatbelts/cell phone use) | 14.06% (27)  |
| Too much screen time/technology use                          | 31.25% (60)  |
| Lack of Exercise                                             | 26.56% (51)  |
| Not getting vaccines to prevent disease                      | 19.79% (38)  |

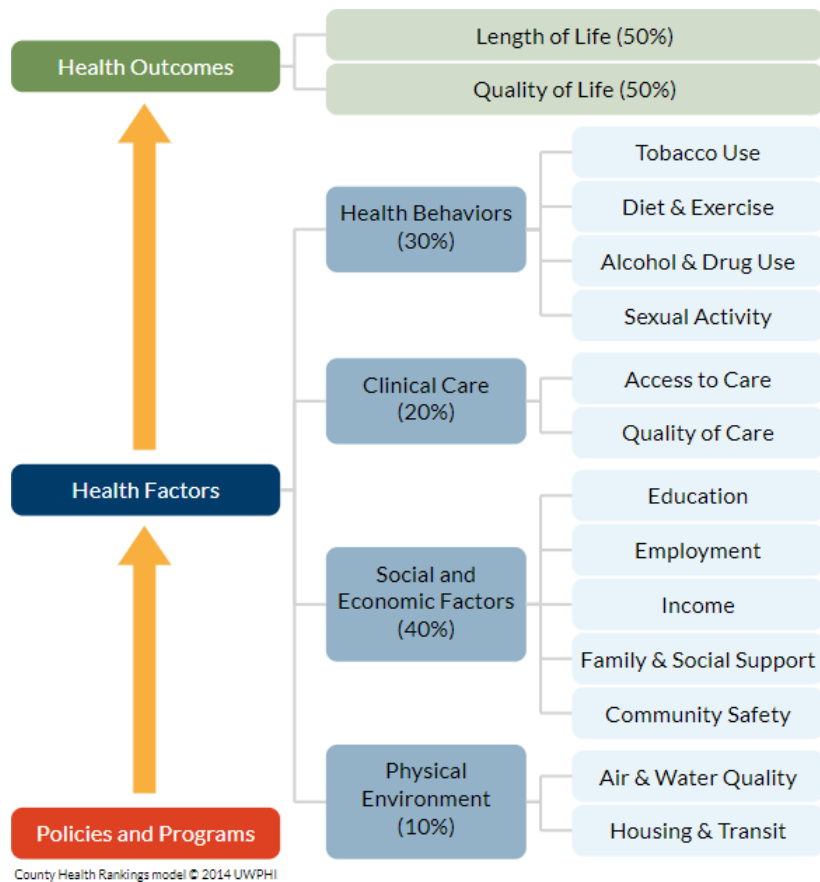


|                                         |             |
|-----------------------------------------|-------------|
| Unfairness towards other races/cultures | 15.63% (30) |
| Dropping Out of School                  | 7.29% (14)  |
| Unsafe Sex                              | 5.73% (11)  |
| Domestic Violence                       | 0.52% (1)   |
| Gambling addictions                     | 0.52% (1)   |
| Dangerous roads                         | 0.52% (1)   |
| Affordable, available housing           | 0.52% (1)   |

The Population Health Institute (“PHI”) publishes annual health data for every county in the United States. The data is aggregated into *health outcomes* and *health factors*. The PHI separates health outcomes into mortality (length of life) and morbidity (quality of life). Health factors are separated into four factors that largely influence the health outcomes: physical environment, society and economics, clinical care, and health behaviors.

| <b>County Health Rankings (out of 102 Illinois Counties)</b> |                    |
|--------------------------------------------------------------|--------------------|
|                                                              | <b>Ogle County</b> |
| Mortality (Length of life)                                   | 29                 |
| Morbidity (Quality of life)                                  | 23                 |
| <b>Overall Health Outcomes</b>                               | <b>22</b>          |
| Health Behaviors                                             | 27                 |
| Clinical Care                                                | 46                 |
| Social & Economic Factors                                    | 33                 |
| Physical Environment                                         | 80                 |
| <b>Overall Health Factors</b>                                | <b>32</b>          |

Ogle County is among the top quartile of Illinois counties in health outcomes, including quality of life and length of life. Ogle County is near the bottom of the rankings in physical environment. The Population Health Institute bases the physical environment rankings on average daily air pollution, drinking water violations per year, percentage of households with at least one of four severe housing problems (overcrowding, high housing costs, lack of kitchen facilities, and lack of plumbing facilities), the percentage of the population that drives alone to work, and the percentage of workers who commute more than 30 minutes to work. Our community does have a lot of individuals who commute alone and who have relatively long commutes, averaging 27 minutes each way. This is mostly due to the number of individuals in our area who live in one community but work in another.



Source: University of Wisconsin Population Health Institute

Because health outcomes are the long-term results of health factors, the current trends indicate that our community members are currently benefitting from relatively positive choices made in the past but may face worsened future health outcomes as the impact of their current health choices are manifested. However, as the county’s health factor rankings improve, the likely impact on future health outcomes should continue to improve as well.

## IV. Forces of Change Assessment

The Forces of Change Assessment provides insight into what is happening in the area currently and also has the ability to affect the health of our community or the local public health system as a whole. It identifies any specific threats or opportunities for change. The product of this assessment will provide a specific, yet comprehensive, list of key forces of change along with their potential impact. This is especially important for taking into consideration the broader contextual environment surrounding communities and their local public health systems. Various aspects of the environment can directly and indirectly cause changes. These influencing factors

can include, but are not limited to: state and federal legislation, new and fast-paced technological advances, organizational changes for health care services, any new shift in the economy or in employment status, and also changes within family structures and gender roles. They are extremely important as they affect the overall health and quality of life of community members, along with how effective the local public health system is at ensuring good health for the community.

This assessment included online feedback from local residents and provided insight into which forces and trends are impacting the general health of the community. Again, only a few residents provided meaningful responses. The comments below provide a synopsis of certain themes inherent in the feedback provided:

The final four questions have to do with forces of change:

- “What is occurring or might occur that affects the health of our community or the local public health system (the public health system is all those entities that play a role in local community health and safety)?” The results are as follows:
  - Response 1: “I am excited about more local transportation and how this can help connect people to resources.”
  - Response 2: “Unable to answer.”
  - Response 3: “Decrease in vaccination rates locally and nationally could potentially lead to outbreak of vaccine preventable disease. More hosts give virus/bacteria more opportunity to mutate and cause decrease in effectiveness of vaccines”.
  - Response 4:” In our community, I’ve noticed more folks dealing with health problems like high blood pressure, diabetes, and weight issues. A lot of that comes down to busy schedules, the cost of healthy food, and not having as many places to be active. Mental health has also become a big issue — more people are dealing with stress, anxiety, and depression, but we don’t have enough local counselors or clinics to help everyone. Another concern is how hard it’s getting to find medical care nearby. Some doctor offices are short-staffed, and people end up waiting weeks for appointments or driving long distances. Between the rising cost of living, limited transportation options, and fewer healthcare workers, it’s putting a lot of pressure on families and our local public health system.
  - Response 5: Government Shutdown, Mental Health, Drug Use, Access to Healthcare and Food Disparity.
  - Response 6: We are currently experiencing a high rate of refusal to vaccinate. Our number of religious exemptions in schools is at an all time high and flu clinic numbers are the lowest they have been in years. Rural areas are experiencing an access to care issue as rural hospitals close down or merge with larger networks and satellite clinics close. Major cuts to public health funding over the last year is also occurring.
  - Response 7: I’m concerned about financial stability of the already low numbers of health care facilities/providers in rural counties. Uncertainty for future funding for LCHD’S to continue to meet their missions.

- Response 8: Rural Desserts-meaning limited access to resources including hospitals and specialties (ob, gastrology, rheumatology, etc), grocery/convenience stores, safety awareness, etc. (Chronic Diseases, Mental Health, Workforce specialty – deficit (Doctors, nurses, well contractors, septic contractors, etc), Old infrastructure)
- Response 9: I believe that the lack of resources within our community for mental health affects the health of the community. As far as I am aware, we do not have inpatient facilities that can house those with substance abuse issues. We have a lack of recourses for mental illness in our area and are pretty limited to Sinnissippi centers. While we do have therapist and counselors in our area, they do not all accept the medical care which is a majority of our patient population.
- “Are there any trends occurring that you see that will have an impact on our community?”
  - Response 1: “N/A”
  - Response 2: “Same as above”
  - Response 3: Again, trend to not vaccinate children could increase illness rates and outbreaks in our community
  - Response 4: Yes, there are a few trends that really stand out. Our population is getting older, so there’s going to be more need for senior care, home health services, and help managing chronic conditions. Mental health awareness is growing, which is a good thing, but our community still needs more resources close to home. I’ve also noticed more people using telehealth, which helps when you live far from town, but it only works if you’ve got decent internet — and a lot of folks around here still don’t. Food insecurity is another growing issue. Groceries are expensive, and we don’t have many stores with affordable healthy options. On the bright side, we’ve got local groups, churches, and schools working together on food pantries, gardens, and wellness programs. That sense of community support is one of our biggest strengths.
  - Response 5: AI, Climate Change, Economic Gap
  - Response 6: Same as stated above, but would also include youth vaping and more frequent severe weather events.
  - Response 7: The cell phone pandemic that in various ways is effecting the mental health of young people in our country. This can affect their ability to socialize, overall happiness, and exposes them to content that they are not mature enough to consume and use to make informed decisions. We have a mental health crisis and I believe this is a contributing factor. Political discord is leading to the public not liking someone based on their opinion. A general lack of concern for our fellow citizens negatively impacts us in many ways, including public health.
  - Response 8: Aging population, declining population, real estate values high, grocery prices high.
  - Response 9: I think the use of telehealth and online medicine/mental health communication will have an impact on society. We see how AI, social media, and technology is affecting our youth. I feel that when you are doing everything online or over the phone you lose touch with the basic needs of human interaction whether that is body language, human touch, or social interactions.

- What forces are occurring locally? Regionally? Nationally? Globally?
  - Response 1: “N/A”
  - Response 2: “What specific threats or opportunities are generated by these occurrences?”
  - Response 3: There does seem to be a national force directed toward making US food supply safer. Talk about decreasing additives/dyes in food that have been shown to have adverse effects and increase chance of obesity in the population has been on the rise. If change is forced on food manufacturers, this could improve the quality of the US food supply and potentially improve health outcomes for the community, and nation as a whole
  - Response 4: **Locally:** We’re dealing with higher costs for just about everything — housing, gas, food — and that adds stress for families. Healthcare access is limited, but we do have some great community efforts, like food drives, local gardens, and health fairs that bring people together and fill some of those gaps. **Regionally:** Rural areas all around us are facing similar challenges, especially with doctor shortages and hospital closures. The good news is that some counties are starting to work together to share healthcare resources, training, and emergency services. **Nationally:** Healthcare costs keep rising, and it’s harder for small-town clinics and hospitals to stay open. But there’s more national focus on preventive care and mental health, which could lead to more funding and programs for rural communities. **Globally:** We’re all seeing the effects of climate change — from stronger storms to changes in farming seasons — and those things can impact our health and food supply. On the other hand, global cooperation in healthcare and research gives us better tools to prepare for things like pandemics and natural disasters
  - Response 5: AI and loss of jobs, Inflation/High Debt creates financial challenges for everyone and Climate Change.
  - Response 6: Politicizing public health jeopardizes the community and places mistrust in the very entity trying to protect their health.
  - Response 7: The political divide of our politicians have at all levels of government, is not allowing them to work on solving our important issues. Proposed good solutions may not gain traction not because of their faults, but by what party proposed them. Compromising appears to be a thing of the past. While the national is debt is not sustainable and more funding is not always the best path forward, it is an opportunity for the state and local public health stakeholders to focus on what programs have the most impact of public health. While all programs are well intended, some may not generate enough positive outcomes versus resources spent. Stakeholders can also use these times of financial uncertainty as an opportunity to reduce redundancy and improve efficiency of their programs.
  - Response 8: All-aging population. IL as a whole-Declining population, as a nation/globe not experiencing yet, but if trends continue of small families or no kids, it could. As a nation, Rising house costs, limited housing options-not globally. Ogle and other rural areas-Workforce shortages due to rural settings.

People want to go to bigger cities to get paid more. Pro-Telehealth has been a huge help everywhere

- Response 9: Obviously with the recent government shut down we have seen there to be more food insecurity than there previously was. Hopefully, this will help to decrease the unemployment rate overall as families are impacted.

In analyzing the responses, the data indicates that although the other three participants provided positive feedback, many of the free-response questions received "N/A" responses.

## Findings:

The received feedback of all four assessments was organized into several priorities that are considered paramount concerns to the health of our population:

- ✓ Mental Health
- ✓ Access to Healthcare
- ✓ Chronic Disease

## Community Health Plan and Strategies

Our local hospital was also required to undergo similar community health needs assessments. The results of their most recent findings is noted as:

| <b><i>ROCHELLE COMMUNITY HOSPITAL</i></b>                                |
|--------------------------------------------------------------------------|
| <b><i>PRIORITIES</i></b>                                                 |
| <i>1. Behavioral Health, including mental health and substance abuse</i> |
| <i>2. Access to healthcare services</i>                                  |
| <i>3. Obesity and chronic diseases</i>                                   |

### ***Our Results and Findings***

As a result of the four assessment processes, our agency has identified the following

priorities (in no particular order). The State Health Improvement Plan was consulted for each of these health priorities.

- ***Mental Health***
- ***Access to healthcare***
- ***Chronic Disease***

*(Note: The objectives contained here are not meant to be comprehensive in approach, but to satisfy requirements that at least one outcome, one impact and one intervention strategy be included in this document. Additional objectives may be developed as part of a larger community-wide response to each of these priority areas.)*

### ***1. Mental Health***

Mental health is an important health concern throughout the state of Illinois as well as within our community. The State Health Improvement Plan (SHIP) noted the importance of this health concern partially due to the fact that “nearly one out of every ten Illinoisans reported experiencing poor mental health 14 or more days of poor mental health in the past month,” (2023). Behavioral health problems, relating to mental health, alcohol, and substance abuse problems, have also been reported to contribute to a large number of emergency department visits.

In the discussions from our focus groups throughout our service area, concern was raised around the topic of access to mental/behavioral health services, especially among youth. According to the CDC, in any given year 1 in 5 Americans will experience a mental illness (Centers for Disease Control and Prevention, 2018). Mental health and physical health are often directly related and can influence one another. Mental illnesses, like anxiety and depression, can greatly affect an individual’s ability to maintain good physical health. Comparatively, chronic diseases and other physical health issues can have an equally as detrimental affect on a person’s mental health. These influences can also act as a cycle, feeding negatively off of each other.

Currently the model for understanding mental health and mental disorders focuses on the interaction between social, environmental, and genetic factors of individuals throughout their lives. Behavioral health researchers focus on risk factors and protective factors; the factors that predispose individuals to mental illness and those that protect individuals against developing them. The successful prevention of mental, emotional, and behavioral (MEB) disorders relies heavily on interdisciplinary strategies and approaches due to these diverse influencing factors. Some risk factors for Mental Illness include: Genetic predisposition, homelessness/unemployment, alcohol and other drug use, discrimination and racial injustice, family conflict or family disorganization, and stressful life events. These risk factors will be taken into consideration as we develop a community-wide plan for addressing this issue.

This particular issue has also been substantiated in the latest (2023) State Health

Improvement Plan. This document notes:

“Across the state, behavioral and mental health was described by communities as a crosscutting theme that was greatly exacerbated by the COVID-19 pandemic. Overall, the partnership identified youth mental health support, an improved behavioral and mental health workforce, and more culturally inclusive practices in these programs and initiatives as emerging trends in behavioral and mental health. The partnership highlighted adult and youth depression and anxiety, other mental health disorders, substance use disorder, overdose, and dual diagnosis as key issues in terms of mental health and substance use disorder.

The SHA/SHIP Partnership developed goals, objectives, and recommended strategies to address these challenges.

Statewide data confirm the increases in mental health problems and substance use disorder throughout Illinois, as well as inequities reflected in sociodemographic disparities, including by race, age, and income level.

#### ***Poor mental health days***

- Slightly more than 1 in 10 residents reported having 14 or more days of poor mental health in the past month.
- The highest prevalence of poor mental health days was seen in those 18–24 years of age, black or African Americans, and those who identified as “other race” and lower income groups.

#### ***Mortality due to drug overdose***

- Mortality due to drug overdose and opioid overdose increased over the period from 2016 to 2020, with the highest rates seen in 2020 across all groups.
- The highest death substance overdose mortality rates were seen among black or African American residents, while the lowest rates were among Hispanic residents and those who identify as “other race.”

#### ***Access to mental health care and substance use disorder treatment***

- The rate of emergency department visits for nonfatal opioid events is highest among black or African American residents, while the rate of hospitalization for nonfatal opioid events is highest among White residents.
- Overall emergency department visit rates for substance or alcohol misuse are highest for black or African American residents.

#### **Mental Health and Substance Use Disorder Goals and Objectives**

- *Goal 1: Improve the mental health and Substance Use Disorder (SUD) system’s infrastructure to support and strengthen prevention and treatment.*



Objective 1: Improve data infrastructure to better understand the needs of children, adolescents, and adults, along with the capacity to address these needs.

Objective 2: Equip the public health workforce to better address behavioral health needs and to provide care more effectively across the lifespan.

Objective 3: Build capacity for increased integration of mental health and SUD with health care and other services across the continuum of care.

Objective 4: Increase funding to support the infrastructure development of the mental health and SUD system to meet the needs of children, adolescents, and adults.

- *Goal 2: Reduce mortality due to mental health conditions and SUD through harm reduction and preventative care strategies.*

Objective 1: Reduce drug overdose mortality following the recommendations of and utilizing the metrics outlined in the Statewide Overdose Action Plan.

Objective 2: Reduce the age-adjusted suicide rate for the general population and populations known to experience higher rates.

Objective 3: Reduce the number of children, adolescents (age 13-17), and young adults (age 18-24) who report experiencing poor mental health for more than one week per month.

Objective 4: Reduce the incidence and prevalence of morbidity and mortality of substance use among adolescents and adults.

Objective 5: Increase community interventions to improve prevention and linkage to care.

- *Goal 3: Increase access to age-appropriate community-based care to reduce institutionalized treatment and incarceration.*

Objective 1: Reduce emergency department visits, hospitalizations, and incarceration by narrowing the treatment gap (between those who have a disorder and those who receive care) and building and sustaining community-based treatment capacity.

Objective 2: Increase access to health care and wrap-around services for populations that have disproportionate incarceration rates and lack of access to services, in particular for people of color and vulnerable populations.

- *Goal 4: Improve the resilience and recovery capital of communities experiencing violence.*

Objective 1: Increase mental health and SUD outreach and support to communities with the highest rates of violence.

Objective 2: Increase efforts to prevent and address adverse childhood experiences (ACEs),

which can have a tremendous impact on future violence victimization and perpetration and lifelong health and opportunity.

Objective 3: Improve data collection and surveillance systems around community violence (intentional injury).

Objective 4: Develop tools and resources to implement a crosscutting approach to prevent community violence.

There has been a lot of research and increased understanding surrounding mental/behavioral health and Mental, Emotional, and Behavioral (MEB) disorders. Some of the developments have included understanding the commonality of MEB, identifying the greatest opportunities for prevention, and the importance of implementing interventions that are relevant to the target audiences. All of this progress supported the significance of understanding protective factors. Healthy People 2030 lists several applicable health objectives, including

- MHMD-1: Reduce the suicide rate.
- MHMD-2: Reduce suicide attempts by adolescents.
- MHMD-3: Increase the proportion of children with mental health problems who get treatment.
- MHMD-4: Increase the proportion of adults with serious mental illness who get treatment.
- MHMD-5: Increase the proportion of adults with depression who get treatment.
- MHMD-6: Increase the proportion of adolescents with depression who get treatment.
- MHMD-7: Increase the proportion of people with substance use and mental health disorders who get treatment for both.
- MHMD-8: Increase the proportion of primary care visits where adolescents and adults are screened for depression.

From our assessments, it was very evident that there was a concern in regards to access to mental/behavioral health services. Additional need for better access to care for depression and anxiety were identified as health concerns for our community, with further focus for education centered on young people and the issues that they face.

These objectives bring our agency a unique opportunity to work in collaboration with local partners to improve access to services, enhance our delivery system, and create better referral systems that will overall better serve our community.

## Outcome Objective:

1. **Increase the proportion of adults with mental health disorders who receive treatment by 2031.**

**Impact Objective:****1.1 Increase depression screening by primary care providers by 2028.****Intervention Strategy:****1.1.1. The Ogle County Health Department will screen clients for depression and develop a referral system with local mental health providers beginning in 2026.**

Many of our clients are considered underserved populations. It is imperative that we work in collaboration with our local mental/behavioral health providers to increase screening measures. By increasing screening measures and linking clients with local resources when needed, our agency can aid in ensuring the provision of adequate treatment for those suffering from mental health issues.

The identified issues surrounding mental health included access to identification and diagnosis of mental health concerns, particularly among youth. There was also significant need identified for better access to care for depression and anxiety. This need included further urgency for education focused on youth and the situations that they are being confronted with.

Improved substance abuse prevention was also identified, along with the need for community involvement and support for this issue. Additionally, increased availability for addicts to seek local support for recovery and overall education were also determined important. The group members also brought up the concern of creating increased awareness about the implications of further legalization and heightened availability of marijuana.

***Actions intended to be taken in order to address the health need:***

- Develop a screening tool with assistance from mental health providers for use with our MCH clients.
- Explore a collaboration with local mental health providers to address local needs for services in mental health, substance abuse, and other areas.
- Explore community coalition involvement with schools to develop a community plan to identify mental health, substance abuse, and other issues faced by youth and to provide education around those issues and activities for youth that will promote mental health and substance abuse avoidance.
- Monitor progress of the actions above by observing changes in numbers screened and referred.

- Advocate for funding of expanded local mental/behavioral health resources.

***Anticipated impact of these actions:***

- Creation of a collaborative effort among healthcare providers and the community to address these issues.
- Identify, coordinate, and promote available local services.
- Expand access to mental/behavioral health services throughout the community.

***Planned collaboration between our agency and other facilities or organizations:***

- Ogle County Board
- Local Mental/Behavioral Health Providers
- Schools

## ***Ogle County – Health Problem Analysis Worksheet***

### ***Mental Health***

#### ***Outcome: Mental Health Conditions***

##### ***Risk Factors:***

Family History

Genetics

Brain Chemistry and Injury

Prenatal Exposure

Chronic Health Conditions

Personality Traits

Poor Coping Skills

Psychological Trauma

Past Mental Illness

Stressful Life Situations

Traumatic Experiences

Adverse Childhood Experiences (ACEs)

Social Isolation and Loneliness

Discrimination and Stigma

Poverty and Homelessness

##### ***Direct Contributing Factors***

Social Determinants of Health

Environmental

Genetic Predisposition

Poverty

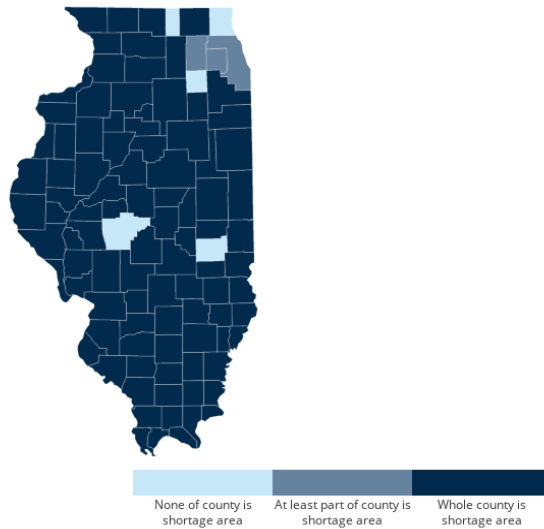
Neighborhood Conditions

## ***2. Access to Healthcare***

Many people in the United States don't get the health care services they need. Healthy People 2030 focuses on improving health by helping people get timely, high-quality health care services. About 1 in 10 people in the United States don't have health insurance.<sup>1</sup> People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses. Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need (Healthy People 2030).

From the Rochelle Community Hospital Community Health Needs Assessment: "Access to Care: Many of our community participants' behavioral health concerns relate closely to access issues. Rochelle Community Hospital does not currently have a focused mental health treatment department, although OSF – St. Katharine's Hospital in Dixon does have a behavioral health treatment department. Additionally, the county health departments, Sinnissippi Centers and other local organizations and providers provide behavioral health services to community. Despite the effort currently being expended to help the community, participants perceived a need for additional counselors with less frequent turnover, a need for more facilities across the continuum of care, and a lack of consistent follow-up and outpatient care that would lead to long-term changes in a person's health. Unfortunately, attracting providers is difficult given our rural environment. The map provided below from the Rural Health Information Hub shows that most of the state of Illinois is facing a mental health professional shortage. Note that the lighter blue area in the northeastern corner of the state, with more mental health providers, is the greater Chicago Metropolitan area.

Health Professional Shortage Areas: Mental Health, by County - Illinois 2025



Source: [data.HRSA.gov](https://data.HRSA.gov).

Dedicating more resources to mental health services would require recruiting more staff with the appropriate credentials, but there is a shortage of mental health providers across the state and nation. The current workforce of mental health providers is aging out of the profession or are burning out and leaving the field and these factors are outpacing the number of incoming mental health professionals. Combining this declining overall number of providers with increasing

consumer demand, the consensus is that this service is likely to remain a major health problem within our community and the nation in the foreseeable future.

In December 2023, the National Center for Health Workforce Analysis issued a report on the shortage of behavioral health care providers in the United States. From that report, “The United States is experiencing a mental health crisis with increased levels of unmet behavioral health needs among people of all ages. The capacity of the behavioral health workforce to meet the demand is limited by supply and distribution challenges. However, the challenges facing the behavioral workforce extend beyond the supply and demand issues and include:

- Patient-level barriers, such as stigma and ability to pay that both hinder access to care
- Provider-level barriers, such as limited scopes of practice, reimbursement challenges, and clinician burnout all of which limit the ability to provide high quality care.”

Similar to mental health, community participants expressed concerns about access to health care treatment services for substance abuse. The two greatest needs expressed by community participants were for additional inpatient and transitional care facilities, although the availability of care depends largely on a person’s financial situation and ability to travel great distances for care. Insurance companies have various positions on whether substance abuse treatment is eligible for coverage and, if so, which facilities may be used. In addition, some insurance providers will not cover services provided by specific types of doctors, nurses and specialists even though those providers may be best able to treat an individual’s needs. Clearly, this is one area of medicine in desperate need of reform at the state and national levels. Unfortunately, attracting substance abuse treatment providers is also difficult given our rural

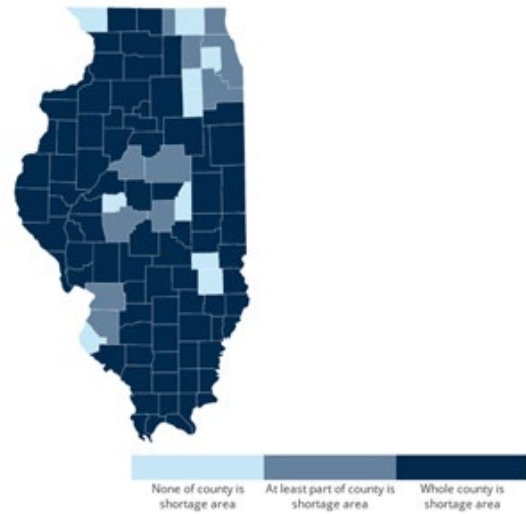
environment.

According to a November 2021 article from Treatment Magazine, “Skilled behavioral healthcare workers have historically been hard to find, not to mention retain. The work isn’t easy and is accompanied by high burnout rates, especially in the addiction treatment field. Layer on a once-in-a-century pandemic, and suddenly the addiction treatment field in the U.S. is faced with an unprecedented workforce shortage. “Back in 2015, Pew Charitable Trusts spotlighted the problem in a first-of-its-kind ‘provider availability index’ that showed how many behavioral health professionals—psychiatrists, counselors and social workers—were available in each state to treat the estimated 20 million people across the country with a substance use disorder (SUD). The numbers ranged from a high of 70 providers for every 1,000 adults with addiction in Vermont to a low of 11 per 1,000 in Nevada. Nationally, according to Pew, the average at the time was 32 behavioral health specialists for every 1,000 people with SUD. The report did not determine an ideal ratio but noted widespread consensus that the workforce was inadequate. One addiction expert in the report called the crisis “severe.” The article further discusses the impact of the COVID pandemic on treatment services: “In many places, it’s only gotten worse since then.... In a special September 2021 Psychiatry Online report, researchers contended that a ‘rapid and substantial’ scaling up of access to effective treatment is needed to address the opioid crisis, which approached 100,000 overdose deaths in the latest 12-month period measured by the Centers for Disease Control and Prevention (CDC). ‘Strategies to increase access are hindered by a lack of treatment providers,’ the paper’s authors say...” Finally, the article discusses the special challenges faced by rural providers. “Many residential treatment centers are located on isolated rural campuses far from urban areas. Recruiting staff to work at these facilities is more difficult—the locale may not be desirable for potential workers who might be weighing the availability of resources such as schools, transportation, shopping, and cultural and recreational opportunities. Additionally, Ventrell notes, the treatment field has slowly evolved from a social model (like the 12 steps) to a medical model in which it is essential to provide medical care. Concentrations such as psychiatry are often not the first choice in medical schools, he says. Add to that the notion that addiction is one of the least understood areas of behavioral health, and the hiring pool becomes even more limited.”



Aside from behavioral health, access to health care services in general was also frequently identified as one of the most significant health needs in our community. Aside from behavioral health issues, concerns related to access to care can generally be classified into the following areas: transportation issues, inappropriate use of the Emergency Room (“E.R.”), insufficient local specialty services, the needs of the low-

Health Professional Shortage Areas: Primary Care, by County - Illinois 2025



Source: [data.hrsa.gov](https://data.hrsa.gov)

income community, access to services outside of normal work hours, and special needs for the Hispanic community. While participants indicated appreciation for the local hospitals, medical clinics and medical providers, they frequently identified community members’ difficulty in physically getting to those locations as a major concern across the area, for multiple reasons. First, participants are concerned about the availability of transportation across the community. Some individuals don’t have and/or can’t afford a working vehicle capable of driving to the necessary healthcare facility. Similarly, others – youth under 16, some elderly individuals, those with physical disabilities – aren’t able to drive themselves even if they have access to a vehicle. Second, those who can’t drive themselves to a healthcare facility may not have family or friends who could drive them. Third, our area has a very limited public transportation system, with those options offering limited times, limited geographic service areas, and/or limited allowed users. Fourth, even for those individuals who have transportation, each healthcare visit requires a significant amount of time, which means time away from work, school and other daily demands. Finally, the winter weather – snow, ice, etc. – can create additional challenges for individuals. While community members generally expressed praise regarding the E.R. facilities in the area they expressed concern over the community’s use of the E.R. First, community participants believe that individuals are delaying or avoiding preventive care to the point that an easily treated condition develops into a more severe issue that requires a trip to the E.R. The causes for such avoidance could include cost, time, lack of personal accountability, ignorance regarding the issue, or a distrust of the medical providers. Whatever the cause, such avoidance results in more intensive care that takes more time and is more costly once it develops into an emergency situation. Although the E.R. is the appropriate place for such emergencies, they could be avoided altogether with more preventive measures initiated by community members. Second, community participants believe that individuals facing acute mental health and substance abuse crises frequently end up in the E.R. to address their condition, with a relatively small number of individuals requiring a fairly large

amount of time and effort to care for. Community members often identified a lack of local specialty services as a community need. Rochelle Community Hospital has only a handful of full-time specialist medical providers, with the remaining specialty services being offered on a part-time basis through contracts with other area hospitals and medical groups. Desired local specialty services identified by participants include OB/GYN, cancer treatment, dialysis, neurology, pulmonology, infectious disease, and pain specialists. These types of services may require traveling greater distances to larger hospitals in Rockford, DeKalb or Chicago, which could be up to a 2-hour drive away. Low-income community members may have additional struggles in receiving effective and thorough health care. As costs have risen, this challenge has expanded into the middle class who do not qualify for government benefits and typically have high deductible health plans. Those who are uninsured or underinsured and low-income may not be able to receive regular preventive care, meaning small health problems may develop into major health problems. Low-income community members face all the same health risks – obesity, mental health issues, substance abuse, heart disease, diabetes, etc. – as other community members, but low-income individuals have fewer alternatives to receive treatment to meet those needs. Interview participants expressed concern about the hours during which health care services and prescriptions can be obtained. Emergency services are available at all times and on all days. However, as individuals work longer hours and/or multiple jobs, it becomes increasingly difficult to leave work during weekdays to go to medical appointments or to fill prescriptions. That concern is magnified for lower-income, elderly, young and disabled individuals who may rely on others for transportation and, therefore, cannot completely control when and how quickly they travel, as well as for more rural individuals. Finally, the local Hispanic community faces the additional barrier of having limited English proficiency. Rochelle Community Hospital utilizes several employees who speak Spanish as a second language for interpretive services but relies mostly on interpretive software to assist in serving these individuals. While the interpretive software is readily available 24 hours per day and is capable of interpreting thousands of languages and dialects, medical information can be difficult to communicate even in your native language and it's important that the details be communicated accurately, so we acknowledge the need to continue to focus on providing the most effective interpretive services to the Hispanic community and others in the area who have limited English proficiency.” (Rochelle Community Hospital).

This priority area is addressed in the most recent State Health Improvement Plan: “Access to health care and wrap-around services is addressed across all of the Healthy Illinois 2028 priority areas. Some of the most common themes related to access to health care and wrap-around services are technology, diversity of public health workers, and alternatives to incarceration.

- Technology – expanding broadband for greater accessibility of telehealth services in health professional shortage areas, including rural communities and health deserts, as well as to facilitate access to health care and wrap-around services for Illinoisans whose child care or transportation needs restrict their ability to travel for health care.

- Diversity of public health workers – for more culturally competent and accessible care, particularly in terms of language; greater availability and accessibility of community health workers and trained midwives.
- Alternatives to incarceration – increasing access to age-appropriate, community-based care to reduce institutionalized treatment and incarceration of residents with mental health and substance use problems; increasing funding for and incentivizing substance use disorder service provision, especially medication-assisted treatment.

A fundamental component of access to care—particularly when it comes to the prevention, protection, and assurance that public health is meant to deliver—is safe, affordable, convenient, and healthy access to transportation between all the places where Illinoisans live, work, and play.”

Although Healthy People 2030 has a total of 49 objectives focused around access to healthcare, there are several that relate directly to those issues particularly salient in Ogle County. The Healthy People objectives that are more generally focused include the following:

- AHS-01: Increase the proportion of people with health insurance.
- AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it.
- AHS-04: Reduce the proportion of people who can’t get medical care when they need it.
- AHS-06: Reduce the proportion of people who can’t get prescription medicines when they need them.
- AHS-07: Increase the proportion of people with a usual primary care provider.
- AHS-08: Increase the proportion of adults who get recommended evidence-based preventive health care.
- AHS-09: Reduce the proportion of emergency department visits with a longer wait time than recommended.
- OH-08: Increase use of the Oral Health care system.
- ECBP-D07: Increase the number of community organizations that provide prevention services.

Although the objectives and intervention strategies are in their developmental stages with local partners, the following provides an early snapshot of intended outcomes.

**Outcome Objective:**

- 2. Reduce the percentage of individuals utilizing Ogle County hospital emergency rooms for non-emergency conditions by 2031.**

**Impact Objective:**

- 2.1 Decrease the number of Ogle County residents identifying the emergency department as their choice of medical care by 2028.**
- 2.2 Increase the number of Ogle County residents indicating they have access to a dentist by 2028.**
- 2.3 Decrease the number of Ogle County residents indicating that they do not seek care by 2028.**

**Intervention Strategy:**

- 2.1.1 The Ogle County Health Department will support assertive linkage navigation/engagement programs which link lower income community members with a medical home and insurance coverage beginning in 2026.**

## ***Ogle County – Health Problem Analysis Worksheet***

### ***Access to Healthcare***

#### ***Outcome:***

Access to Healthcare

#### ***Risk Factors:***

Low Socioeconomic Status

Geographical Barriers

Lack of a Regular Healthcare Provider

Health Literacy

Language Barriers

Provider Shortages

Systemic Issues

#### ***Direct Contributing Factors:***

Can be grouped into Individual Factors, Systemic Factors, Environmental Factors and include such things as:

Service Availability

Health Literacy

Inconvenient Hours/Wait Times

Accommodation

Quality of Care

Acceptability

Affordability

Health Insurance Coverage

Availability

Income and Wealth

Accessibility

Financial Stress

Transportation

Shortage of Providers

### ***3. Chronic Disease***

From the Rochelle Community Hospital Assessment: “Like the rest of the country, our community members frequently identified obesity as a health concern, related to both healthy eating and healthy living, as well as the attendant chronic diseases that may arise from it. As of August 2023, 40.3% of adults in the United States were obese and 9.4% of adults were severely obese, with both prevalences being slightly higher in women than in men. Illinois and our community are healthier, with 34.3% of Illinois adults being obese and 35.9% of adults in our community being obese. However, that still means more than one in three adults in our community are classified as obese. Participants believe that obesity in our community is the result of multiple issues including difficulty accessing healthy foods, being able to turn those healthy foods into a meal that people willingly eat, unhealthy living habits, and a general mass complacency that obesity is just normal now. The first obstacle to healthy eating in our community is being able to obtain healthy foods. While Rochelle and Dixon have major national grocery chains like Walmart and Aldi, many of our smaller towns and communities have more limited options for grocery shopping, like smaller grocery stores, convenience stores, gas stations, or no local grocery options at all. These smaller stores naturally have fewer options for the types of foods to purchase. Therefore, individuals in more rural areas or who have difficulty with transportation face greater barriers in getting to the store to buy groceries. The second obstacle to healthy eating is being able to afford healthier foods like proteins, fruits and vegetables. Community participants expressed appreciation that our stores, including Walmart, Aldi, SuperValu and Dollar General, seem to provide foods at more reasonable prices while also acknowledging that healthier whole foods tend to be more expensive than heavily processed (i.e. boxed, canned or frozen) foods. Similarly, interview participants indicated that the majority of meals available in local restaurants seem to be of less healthy nature. The third obstacle to healthy eating is the food preparer having knowledge of how to turn healthy raw ingredients into a meal that they and their families will eat, as well as the time to prepare such a meal. Again, as individuals spend more time on other tasks – working longer hours, working more jobs, spending more time on social media and other online activities, etc. – they have less time available for other daily tasks, such as preparing a home-cooked meal. Finally, as these home-cooked meals become less frequent, preparers lose knowledge practice while family members simultaneously become less comfortable with those healthier meals. Interview participants indicated that unhealthy living habits in our community stem from a lack of consistent daily activity, a natural movement towards sedentary jobs and technology-based activities and insufficient use of locally available exercise options, each of which is exacerbated by challenging winter weather for a large portion of the year.

According to a 2025 report, “screen time” statistics in the United States were as follows in 2023:

- Adults spent an average of 7 hours, 3 minutes on screens daily, which was 23 minutes higher than the global average and 33 minutes higher than the 2017 average.
- Gen Z (i.e., individuals born between 1997 and 2012) spent an average of 9 hours on

screens daily.

- Millennials (i.e., individuals born between 1981 and 1996) spent an average of 6 hours, 42 minutes on screens daily.
- 53% of children aged 8-12 owned smartphones.

While interview participants feel our community may be slightly better than the national averages, they feel the overall trends of increased screen time and decreased physical activity are accurate for our community. Interview participants also expressed concerns regarding our community's use of available exercise options. Larger communities like Rochelle and Dixon have more gyms, parks, recreational leagues and school-based exercise opportunities. Those options decrease significantly in smaller communities. However, even in the larger communities, participants indicated that the community doesn't appropriately utilize the available resources. It's unclear why that's the case, with possible explanations including cost, time and apathy. Obesity is a major concern across the United States because of the related health issues that it can cause.

According to the Mayo Clinic, people with obesity are more likely to develop a number of potentially serious health problems, including:

- Heart disease and strokes: obesity makes you more likely to have high blood pressure and abnormal cholesterol levels, which are risk factors for heart disease and strokes.
- Type 2 diabetes: obesity can affect the way the body uses insulin to control blood sugar levels, which raises the risk of insulin resistance and diabetes.
- Certain cancers: obesity may increase the risk of cancer of the uterus, cervix, endometrium, ovary, breast, colon, rectum, esophagus, liver, gallbladder, pancreas, kidney and prostate.
- Digestive problems: obesity increases the likelihood of developing heartburn, gallbladder disease and liver problems.
- Sleep apnea: people with obesity are more likely to have sleep apnea, a potentially serious disorder in which breathing repeatedly stops and starts during sleep.
- Osteoarthritis: obesity increases the stress placed on weight-bearing joints, in addition to promoting inflammation within the body, which may lead to complications such as osteoarthritis." (Rochelle Community Hospital, 2025).

Chronic Disease was also noted in the State Health Improvement Plan as a priority statewide. From this document:

"Chronic disease in Illinois reflects inequities in regional and sociodemographic disparities:

- Arthritis and functional disability – more concentrated in areas outside of Chicago metropolitan areas and among rural Illinoisans.
- Diabetes – more prevalent among Hispanic and black or African American residents, in nonurban areas, and among those with less than a high school diploma.

- Adult asthma – more prevalent among black or African American residents and those who identify as “other race” as well as for females and lower-income households.
- Obesity – highest prevalence among black or African American residents and in nonurban areas of the state; similar, though higher, rates of obesity are seen among those without a college degree.
- High blood pressure and high cholesterol – higher prevalence among black or African American, White, and nonurban residents.

Through the SHIP process, the partnership identified some of the most important chronic diseases and factors impacting Illinoisans to include asthma, diabetes, cardiovascular disease, hypertension, nutrition, and oral health. focus group participants, including service providers and people with lived experience, also shared concerns about how the COVID-19 pandemic and pre-existing conditions compounded to make chronic conditions worse. The SHA/ SHIP Partnership developed goals, objectives, and recommended strategies to address the challenges related to chronic disease.

#### Chronic Disease Goals and Objectives:

##### ***Goal 1: Increase opportunities for tobacco free living.***

- Objective 1: Reduce the percentage of Illinois adults and youth reporting using commercial tobacco products (including e-cigarettes, vaping, combustible tobacco products, smokeless tobacco, etc.).
- Objective 2: Strengthen public health infrastructure through funding, surveillance, and workforce capacity for tobacco prevention.
- Objective 3: Reduce secondhand smoke in cars, housing, outdoor spaces, etc.

##### ***Goal 2: Decrease preventable chronic diseases through nutrition.***

- Objective 1: Increase the number of local organizations/businesses that implement institutional policy and systems change that support the consumption of nourishing foods.
- Objective 2: Increase access to sufficient, affordable, nourishing, culturally responsive and consumed food, including by maximizing access to and participation in nutrition assistance programs.
- Objective 3: Expand healthy lifestyle services provision and promotion, including in schools and health professional programs, and ensure advice aligns with learners’ lives, conditions, and cultural needs and preferences.

##### ***Goal 3: Increase opportunities for active living.***

- Objective 1: Improve access to physical activity in schools.
- Objective 2: Improve workplace wellness to encourage and to improve access to active



lifestyles for adults.

- Objective 3: Improve the built environment to increase active living in priority communities.
- Objective 4: Develop a cross-sectoral public health campaign to promote and to support active living.

***Goal 4: Increase community-clinical linkages to reduce the incidence and burden of chronic diseases.***

- Objective 1: Expand the role of and access to community health workers (CHWs).
- Objective 2: Improve data collection and sharing practices across the public health system.
- Objective 3: Improve access to preventative and disease-management programs.
- Objective 4: Reduce cost barriers.
- Objective 5: Increase assessment of family history, preventative screenings, and lifestyle modifications to prevent onset and to reduce the impact of chronic disease.”

Although Healthy People 2030 has many different objectives focused around the different forms of Chronic Disease, there are several that are highlighted in this document as a sample and relate directly to those issues particularly salient in Ogle County, including the following:

***Heart Disease and Stroke***

|         |                                                                                                       |
|---------|-------------------------------------------------------------------------------------------------------|
| HDS-D03 | Increase the proportion of adult heart attack survivors who are referred to a rehabilitation program. |
| HDS-D05 | Increase the proportion of adult stroke survivors who participate in rehabilitation services.         |
| HDS-01  | Improve cardiovascular health in adults.                                                              |
| HDS-02  | Reduce coronary heart disease deaths.                                                                 |
| HDS-03  | Reduce stroke deaths.                                                                                 |

***Cancer***

|       |                                                                                                     |
|-------|-----------------------------------------------------------------------------------------------------|
| C-11  | Increase the proportion of cancer survivors who are living 5-years or longer after diagnosis.       |
| C-R01 | Increase quality of life for cancer survivors.                                                      |
| C-R02 | Increase the proportion of people who discuss interventions to prevent cancer with their providers. |

- C-01 Reduce the overall cancer death rate.
- C-04 Reduce the female breast cancer death rate.
- C-06 Reduce the colorectal cancer death rate.
- C-08 Reduce the prostate cancer death rate.
- C-10 Reduce the proportion of students in grades 9 through 12 who report sunburn.

### ***Diabetes***

- D-01 Reduce the number of diabetes cases diagnosed yearly.
- D-04 Increase the proportion of adults with diabetes who have a yearly eye exam.
- D-06 Increase the proportion of people with diabetes who get formal diabetes education.
- D-07 Increase the proportion of adults with diabetes using insulin who monitor their blood sugar daily.
- D-09 Reduce the rate of death from any cause in adults with diabetes.

Although the objectives and intervention strategies are in their developmental stages with local partners, the following provides an early snapshot of intended outcomes.

### **Outcome Objective:**

- 3.1 **Reduce the mortality rate due to Heart Disease by 10 percent by 2031. (Baseline: 165.8 per 100,000. Source: [https://hdpulse.nimhd.nih.gov/data-portal/mortality/table?age=001&age\\_options=age\\_11&cod=250&cod\\_options=cod\\_15&comparison=states\\_to\\_us&comparison\\_options=comparison\\_statename\\_to\\_us&race=00&race\\_options=race\\_6&ratetype=aa&ratetype\\_options=ratetype\\_2&ruralurban=0&ruralurban\\_options=ruralurban\\_3&sex=0&sex\\_options=sex\\_3&statefips=17&statefips\\_options=area\\_states&yeargroup=5&yeargroup\\_options=yearmort\\_2](https://hdpulse.nimhd.nih.gov/data-portal/mortality/table?age=001&age_options=age_11&cod=250&cod_options=cod_15&comparison=states_to_us&comparison_options=comparison_statename_to_us&race=00&race_options=race_6&ratetype=aa&ratetype_options=ratetype_2&ruralurban=0&ruralurban_options=ruralurban_3&sex=0&sex_options=sex_3&statefips=17&statefips_options=area_states&yeargroup=5&yeargroup_options=yearmort_2))**
- 3.2 **Reduce the mortality rate due to Cancer by 10 percent by 2031. (Baseline: 152.2 per 100,000. Source: <https://www.statecancerprofiles.cancer.gov/deathrates/index.php?stateFIPS=17&areatype=county&cancer=001&race=00&sex=2&age=001&type=death&sortVariableName=rate&sortOrder=default#results>).**
- 3.3 **Reduce the mortality rate due to Stroke by 10 percent by 2031. (Baseline: 71 per 100,000. Source: <https://www.cdc.gov/heart-disease-and-stroke-data/widget/index.html>).**
- 3.4 **Reduce the mortality rate due to Diabetes by 10 percent by 2031. (Baseline: 24.2 per 100,000. Source: [https://hdpulse.nimhd.nih.gov/data-portal/mortality/table?age=001&age\\_options=age\\_11&cod=254&cod\\_options=cod\\_15&comparison=counties\\_to\\_us&comparison\\_options=comparison\\_counties&race=0](https://hdpulse.nimhd.nih.gov/data-portal/mortality/table?age=001&age_options=age_11&cod=254&cod_options=cod_15&comparison=counties_to_us&comparison_options=comparison_counties&race=0))**

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comparison options=cods or areas&function=getTable&path=mortality)

### Impact Objective:

- 3.1.1 Decrease the percentage of Ogle County residents that smoke to no more than 13 percent by 2028. (Baseline: 19 percent. Source: <https://www.countyhealthrankings.org/health-data/illinois/ogle?year=2025#population-health>)
- 3.1.2 Decrease the percentage of Ogle County residents that are obese to no more than 30 percent by 2028. Baseline: 36 percent. Source: <https://www.countyhealthrankings.org/health-data/illinois/ogle?year=2025#population-health>)
- 3.1.3 Decrease the percentage of Ogle County residents indicating that they are physically inactive to 20 percent by 2028. Baseline: 26 percent. Source: <https://www.countyhealthrankings.org/health-data/illinois/ogle?year=2025#population-health>)

### Intervention Strategy:

- 3.1.1.1 The Ogle County Health Department will develop health promotion materials focused around smoking and health by 2026.

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:

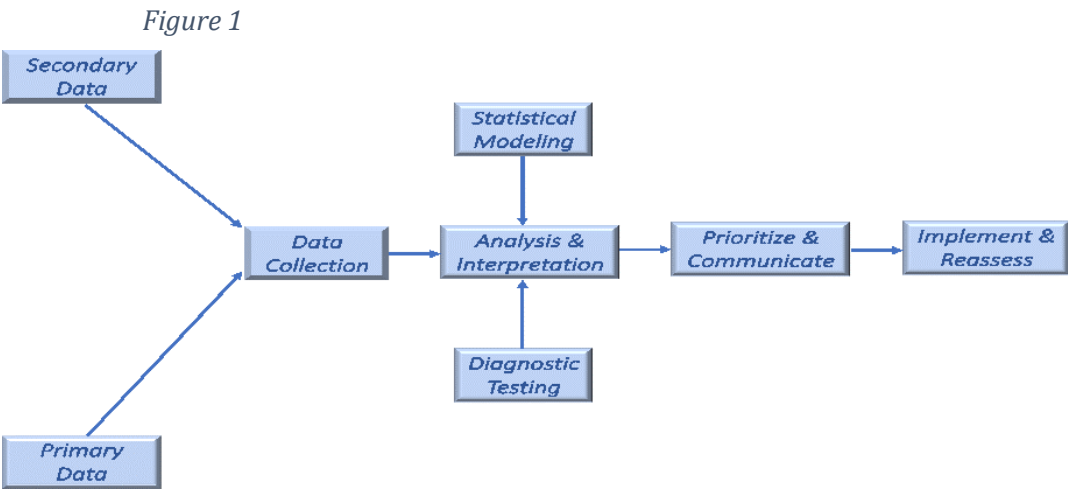
- **Behavioral Health – Mental Health**
- **Access to Healthcare**

# 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).



## 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](mailto: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:

$$n = (Nz^2pq)/(E^2 (N-1) + z^2 pq)$$

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 1<sup>st</sup> 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,  $\chi^2$  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

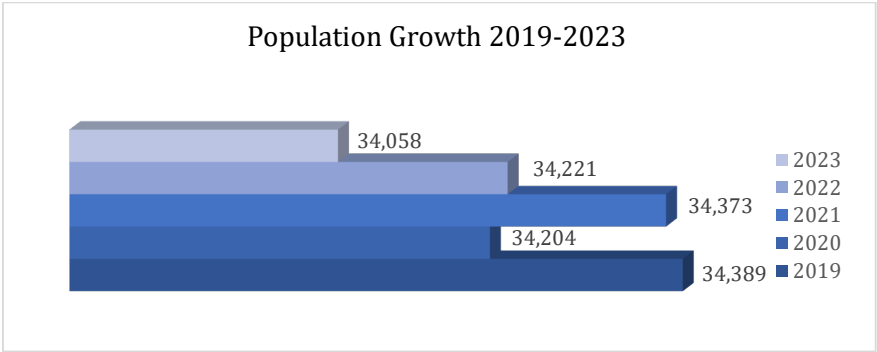
## 1.1 Population

*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

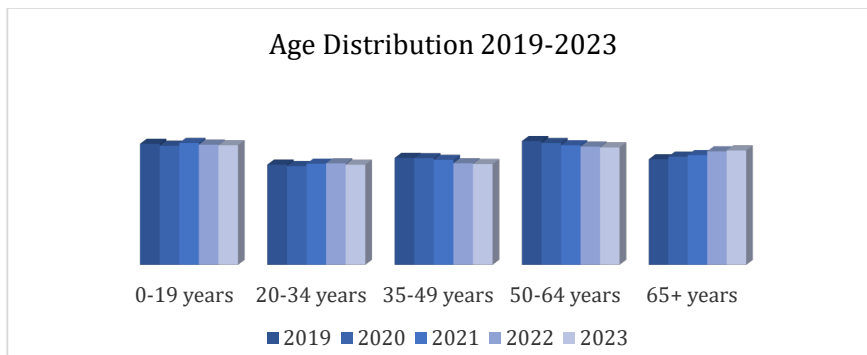
## 1.2 Age, Gender and Race Distribution

*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

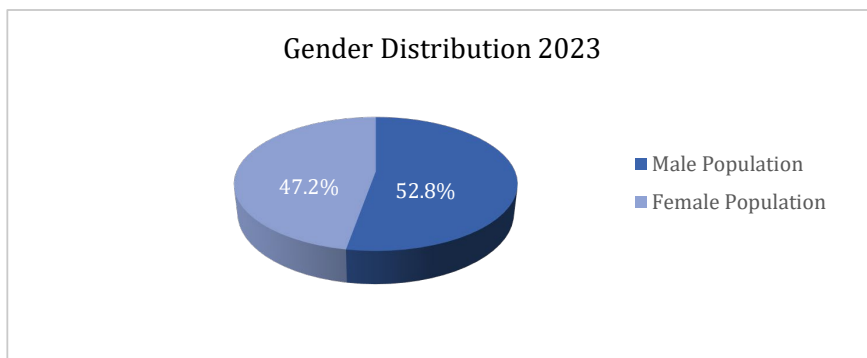


Source: United States Census Bureau

## Gender

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

Figure 5

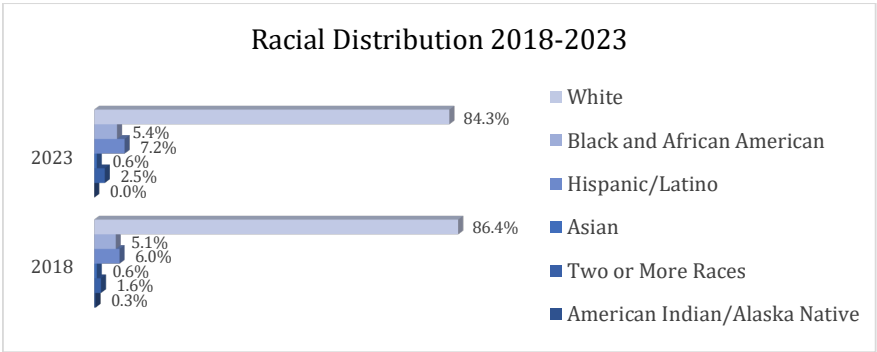


Source: United States Census Bureau

## 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



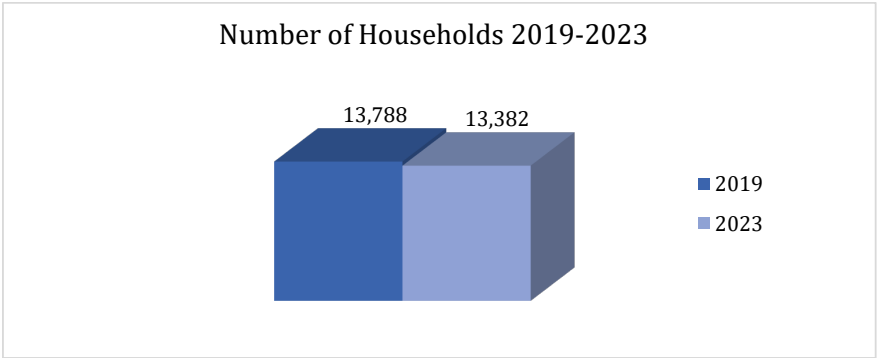
Source: United States Census Bureau

### 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



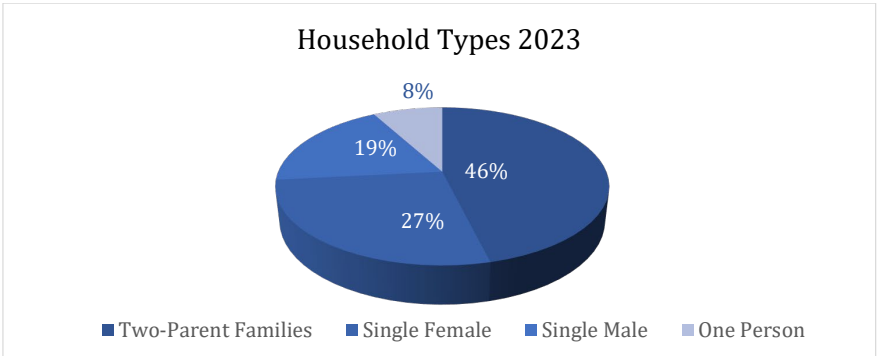
Source: United States Census Bureau

### 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

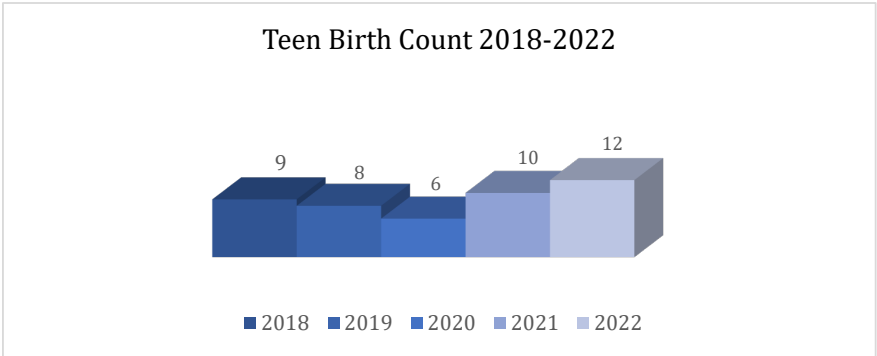


Source: United States Census Bureau

## 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

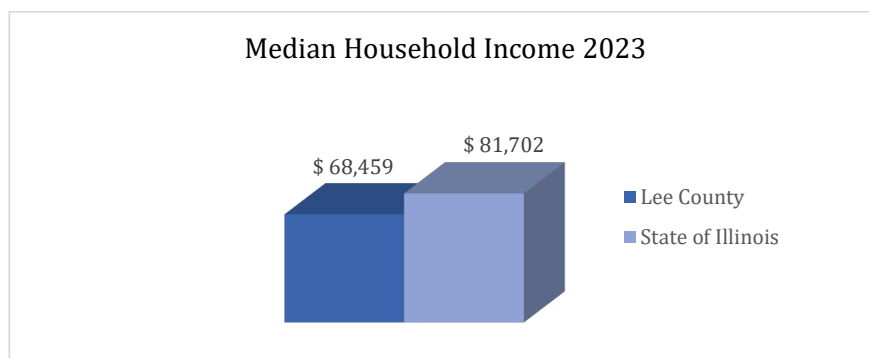
## 1.4 Economic Information

**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

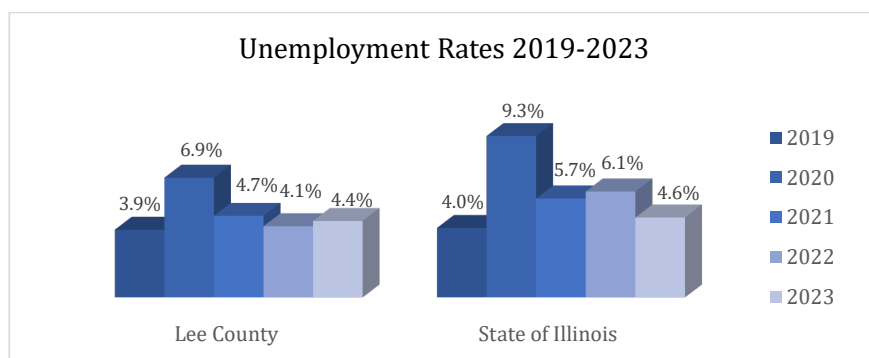


Source: United States Census Bureau

## 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

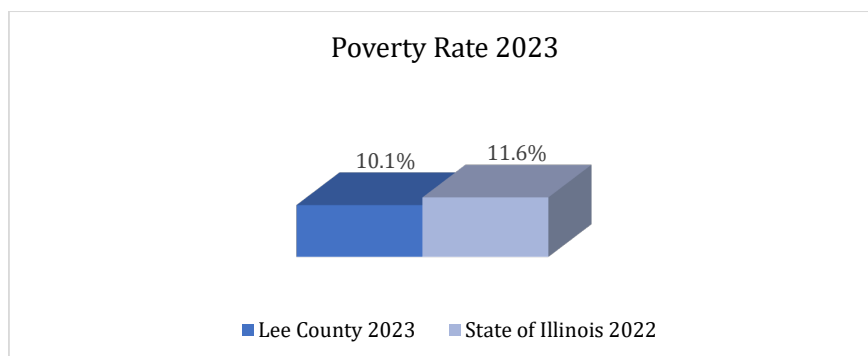


Source: Bureau of Labor Statistics

## 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

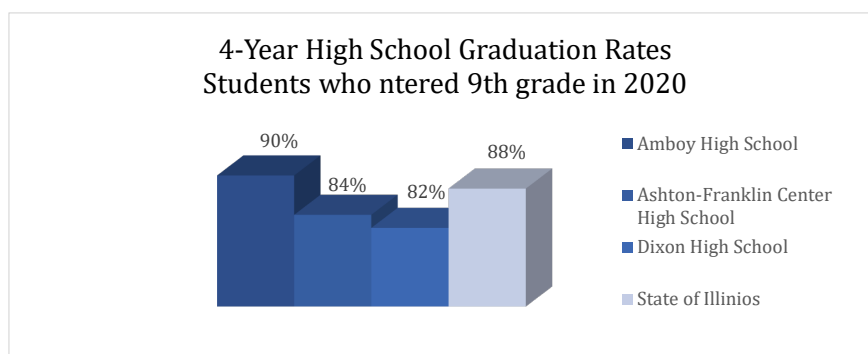
## 1.5 Education

**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

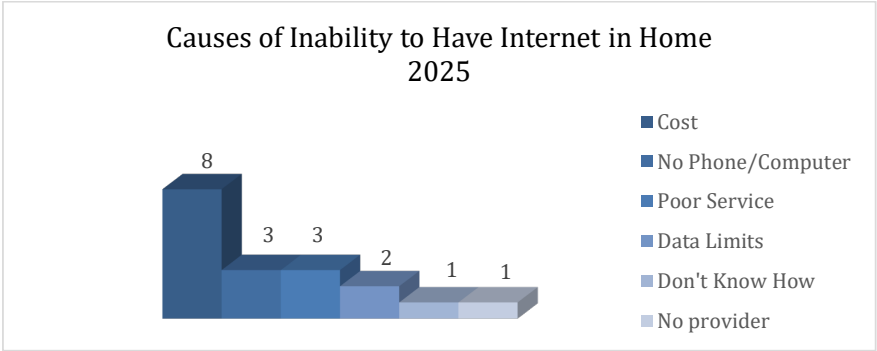


Source: Illinois Report Card

## 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

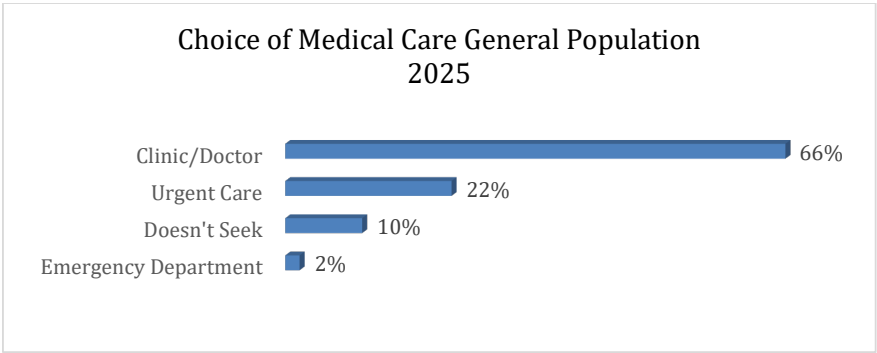
### 2.1 Accessibility

*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

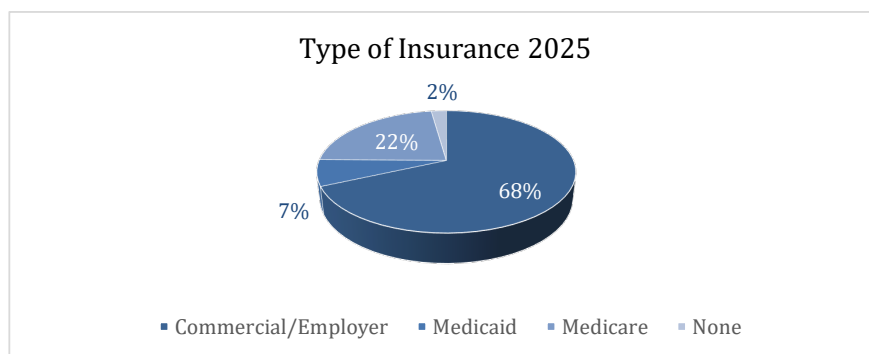
Several factors show significant relationships with an individual's choice of medical care. The following relationships were found using correlational analyses.

- **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).

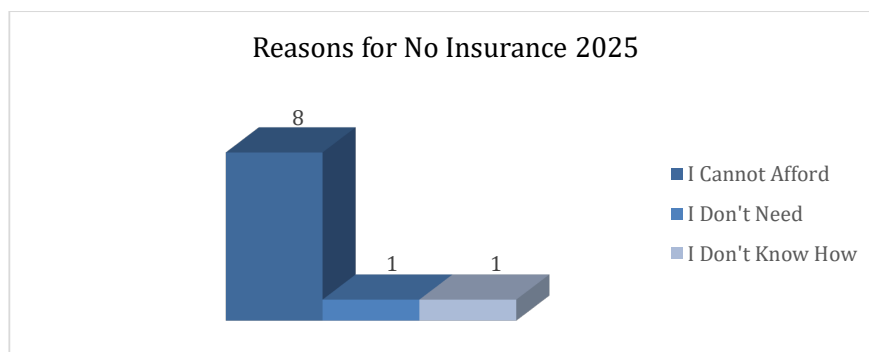
Figure 16



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.

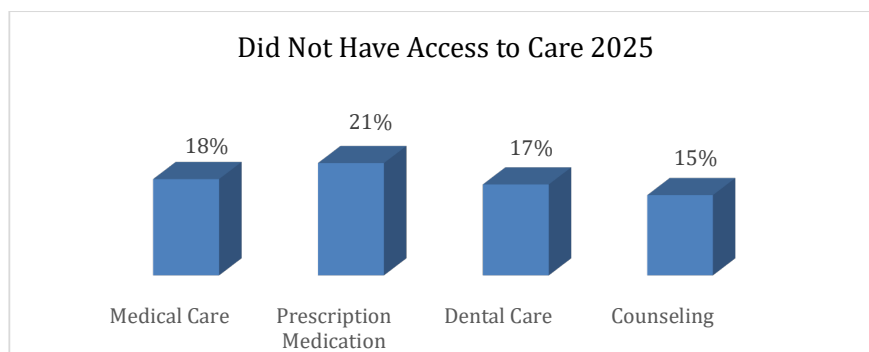
- **Medicare** tends to be used more frequently by older people, those with lower education, those with lower income, and those in an unstable housing environment.
- **Medicaid** tends to be used more frequently by those with lower education and those with lower income.
- **Private Insurance** is used more often by 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

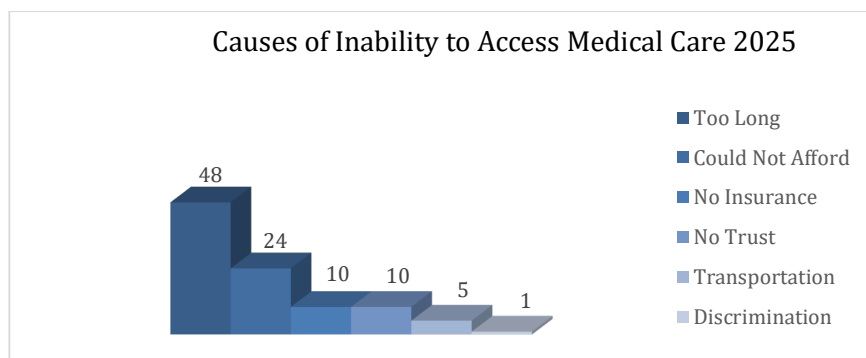
Several characteristics show a significant relationship with an individual's ability to access care when needed. The following relationships were found using correlational analyses.

- **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

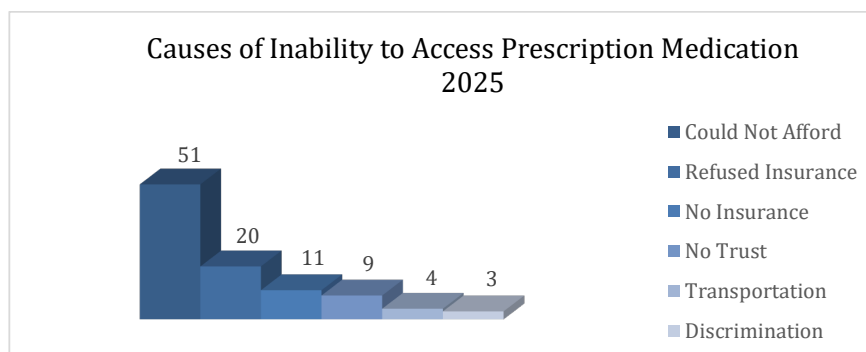


Source: CHNA Survey

## 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

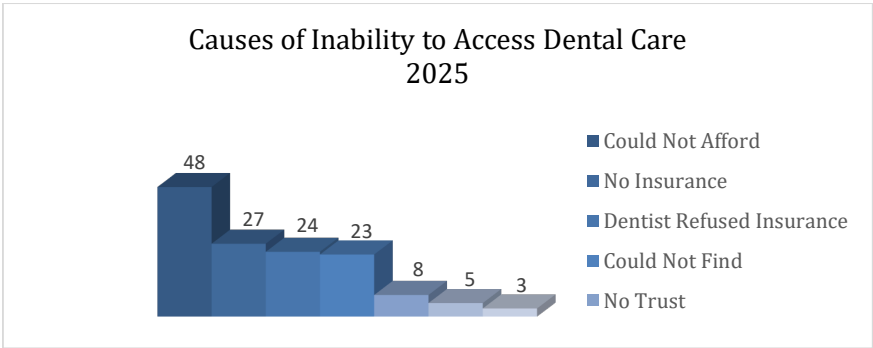


Source: CHNA Survey

## 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

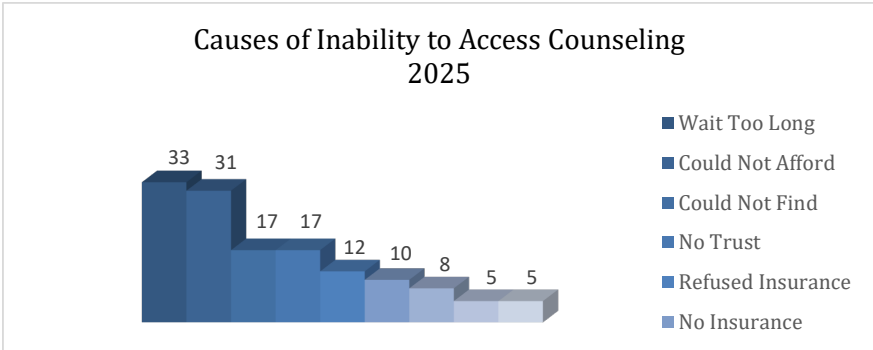


Source: CHNA Survey

## 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

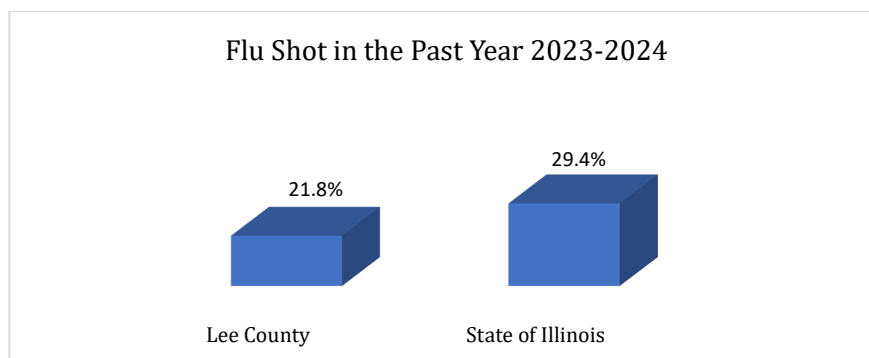
## 2.2 Wellness

**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

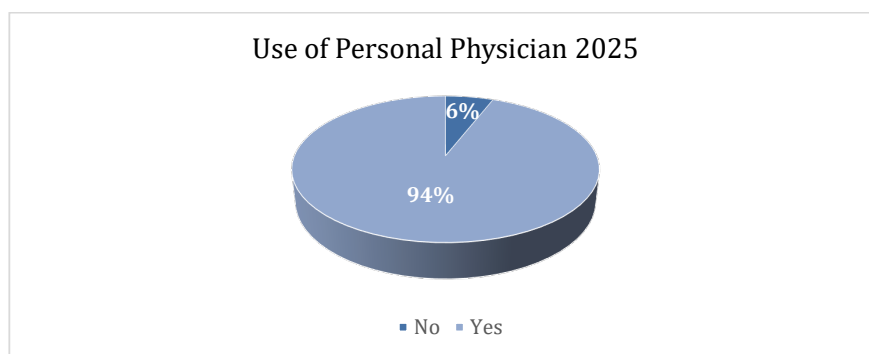


Source: Illinois Department of Public Health (IDPH)

## 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.

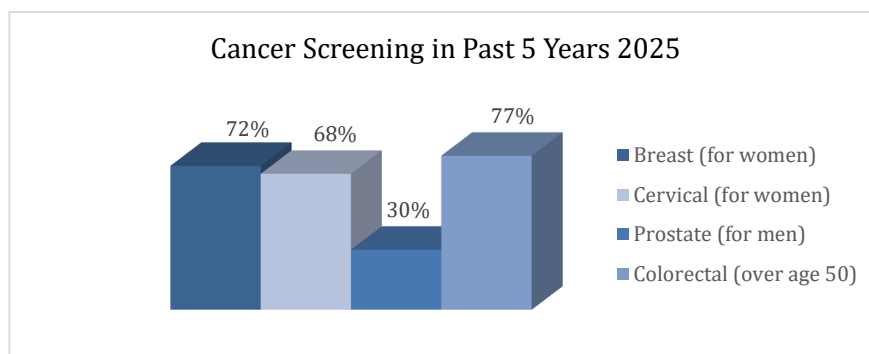
- **Having a personal physician** tends to be more likely for those with higher education.

## 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.

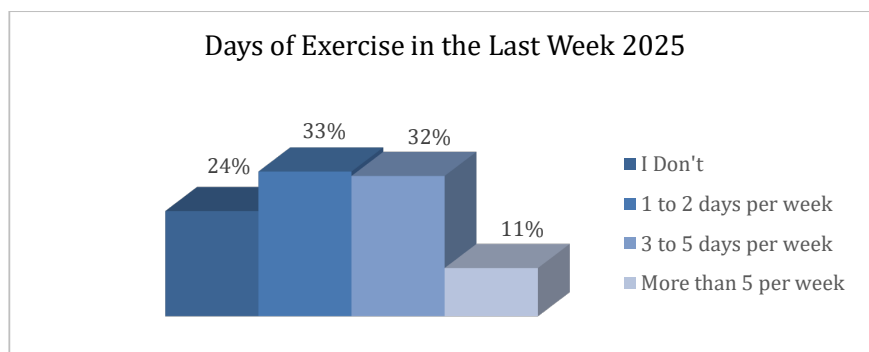
- **Breast screening** tends to be more likely for older women. Those women who are not White and women in an unstable housing environment are less likely to have a breast screening.
- **Cervical screening** tends to be less likely for older women.
- **Prostate screening** tends to be more likely for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

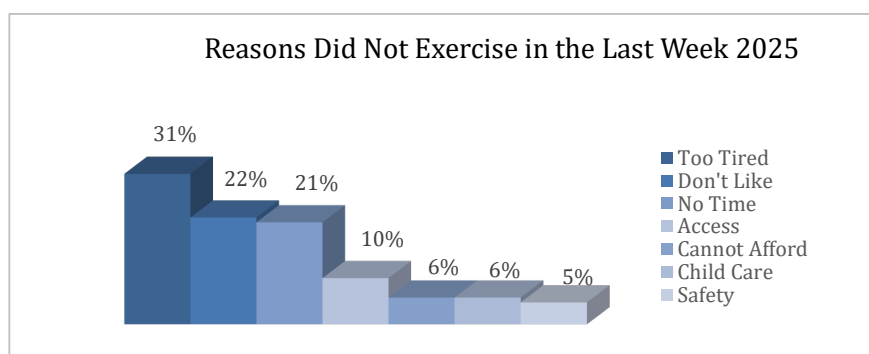
Figure 26



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.

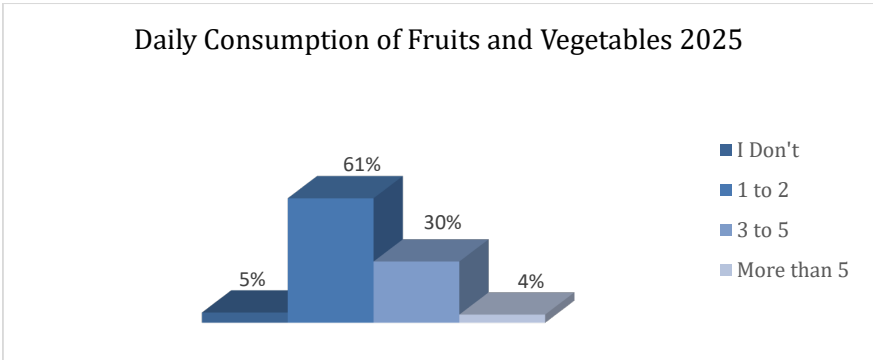
- **Frequency of exercise** did not have any significant correlates.

## 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).

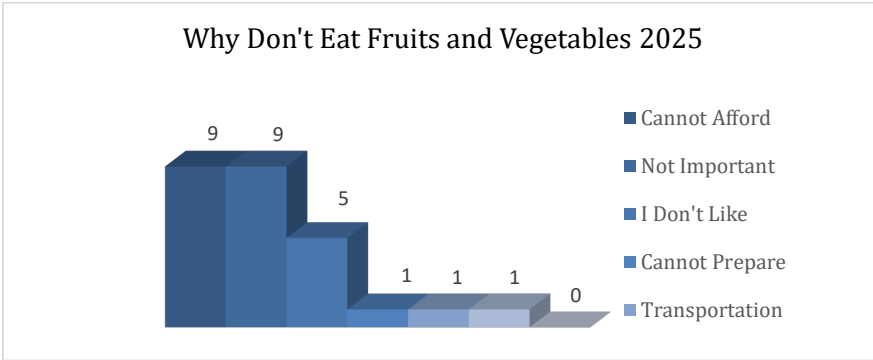
Figure 28



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.

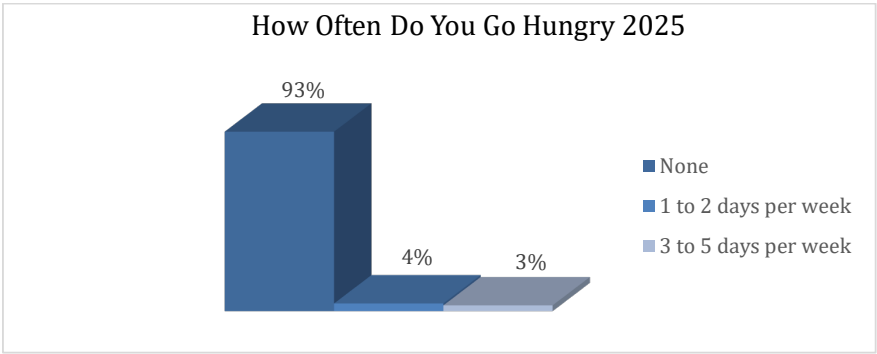
## 2.3 Understanding Food Insecurity

*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.

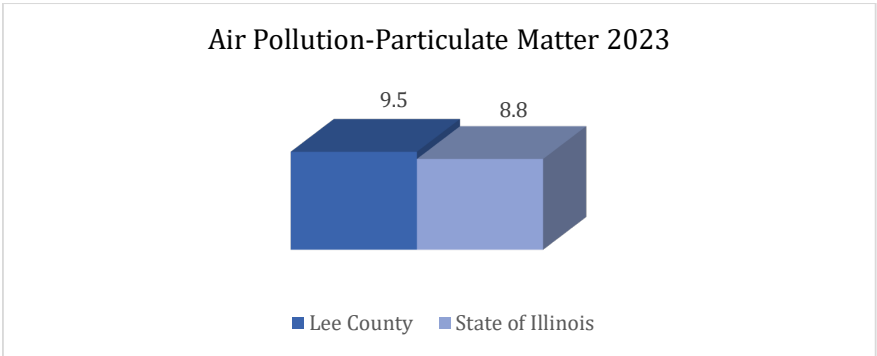
## 2.4 Physical Environment

*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

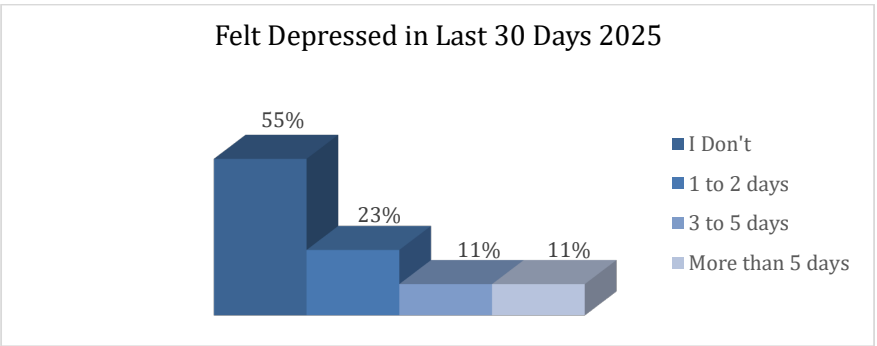
2.5 Health Status

*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

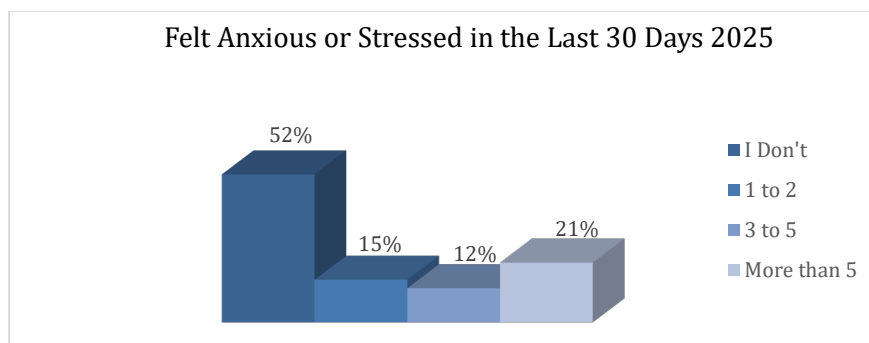
The survey asked respondents to indicate specific issues, such as depression and stress/anxiety. Of the respondents, 55% indicated they did not feel depressed in the last 30 days (Figure 32) and 52% indicated they did not feel anxious or stressed (Figure 33).

Figure 32



Source: CHNA Survey

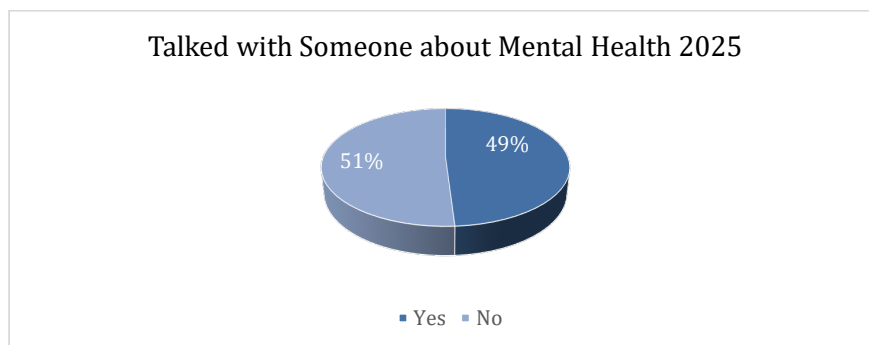
Figure 33



Source: CHNA Survey

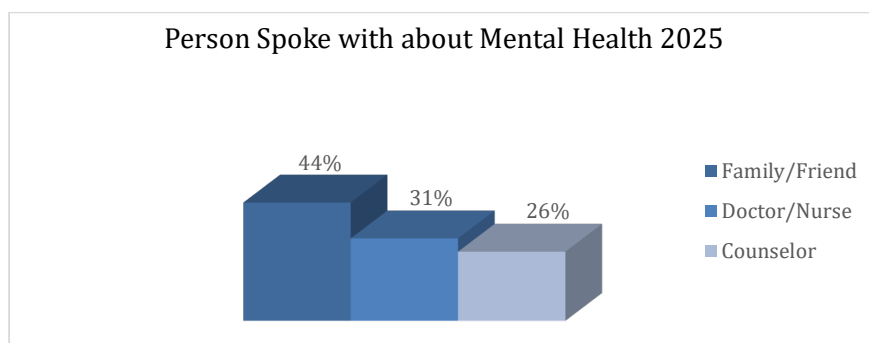
Respondents were also asked if they spoke with anyone about their mental health in the past year. Of the respondents, 49% indicated that they spoke to someone (Figure 34), with the most common response was a family member or friend (44%) (Figure 35).

Figure 34



Source: CHNA Survey

Figure 35



Source: CHNA Survey

## Social Drivers Related to Behavioral Health

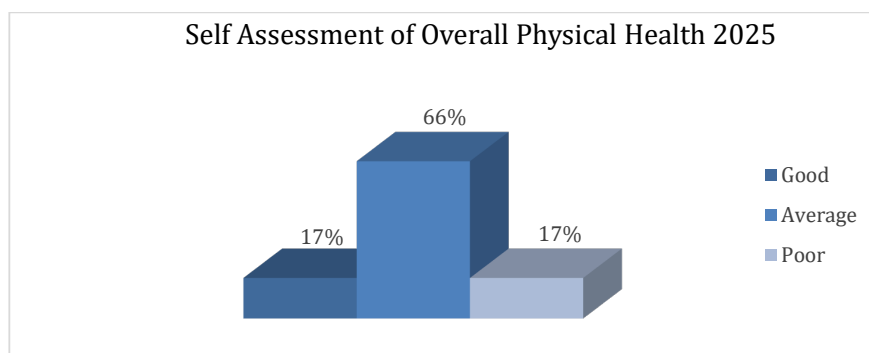
Multiple characteristics show significant relationships with behavioral health. The following relationships were found using correlational analyses.

- **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).

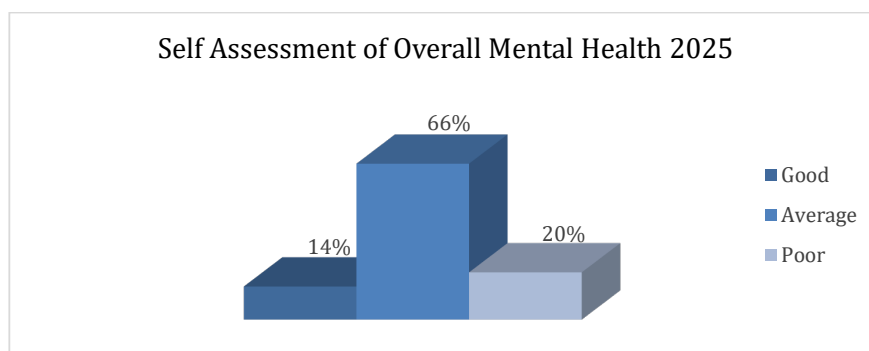
Figure 36



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 |

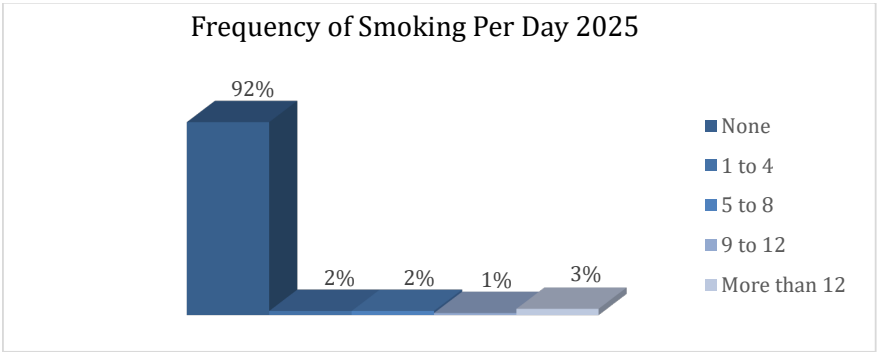
# CHAPTER 3: SYMPTOMS AND PREDICTORS

## 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.

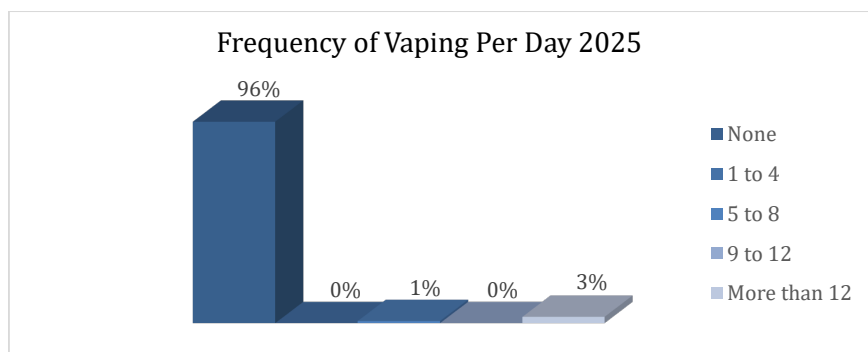
CHNA survey data show 92% of respondents do not smoke, and only 3% state they smoke more than 12 times per day (Figure 38). The percentage of those who state they vape on a daily basis is 4% and 3% vape more than 12 times per day (Figure 39).

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

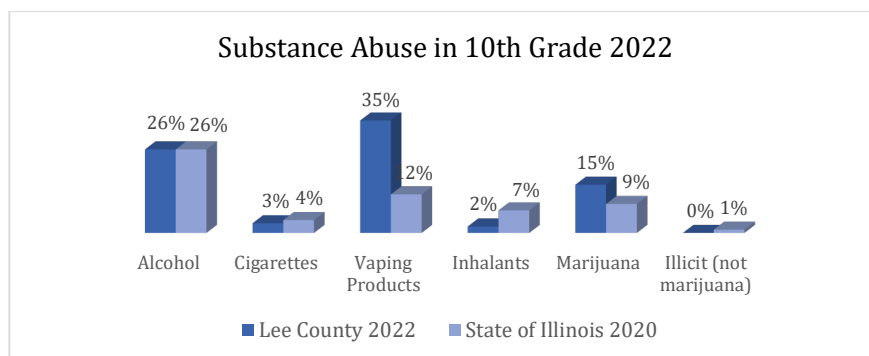
*Importance of the Measure:* Alcohol and drugs impair decision-making, often leading to adverse consequences and outcomes. Research suggests that alcohol is a gateway drug for youth, leading to increased usage of controlled substances in adulthood. Accordingly, the substance use values and behaviors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

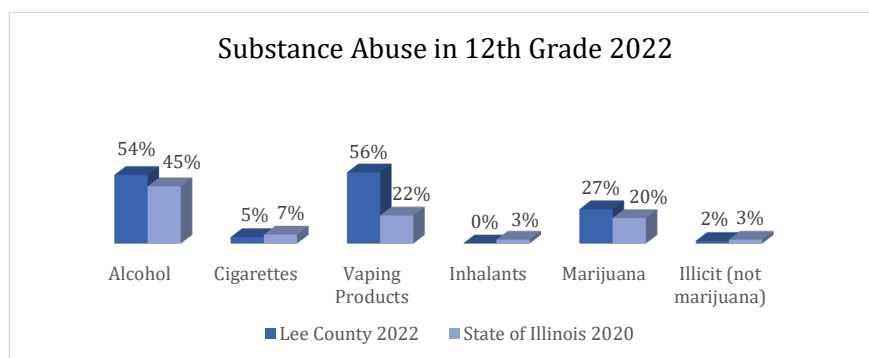
Among 12th graders, the most recent data available for Lee County is 2022 and the State of Illinois data is from 2020. These data show Lee County levels are significantly higher than State of Illinois averages in alcohol, vaping products, and marijuana. Lee County levels are lower for cigarettes, inhalants,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

Figure 40



Source: University of Illinois Center for Prevention Research and Development

Figure 41

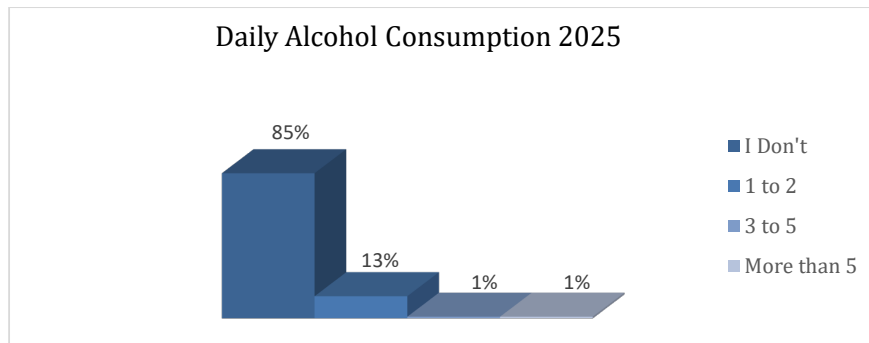


Source: University of Illinois Center for Prevention Research and Development

## Adult Substance Use

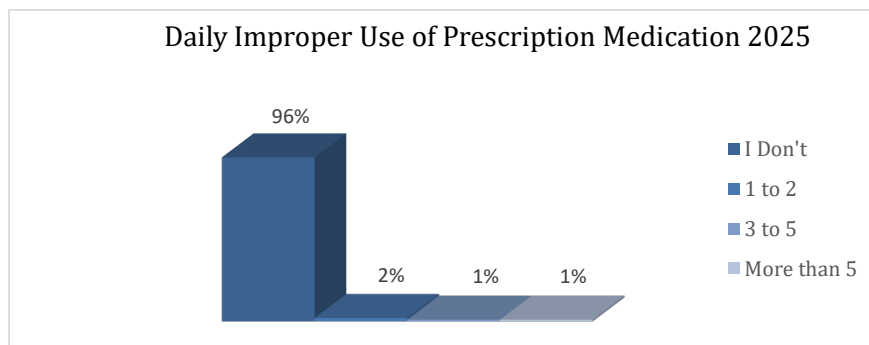
The CHNA survey asked respondents to indicate their usage of several substances. Of respondents, 85% indicated they did not consume alcohol on a typical day (Figure 42). Additionally, 96% indicated they do not take prescription medication improperly, including opioids, on a typical day (Figure 43). Furthermore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



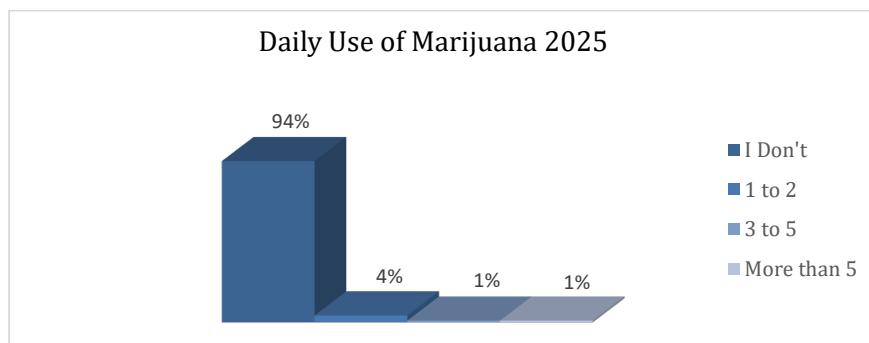
Source: CHNA Survey

Figure 43



Source: CHNA Survey

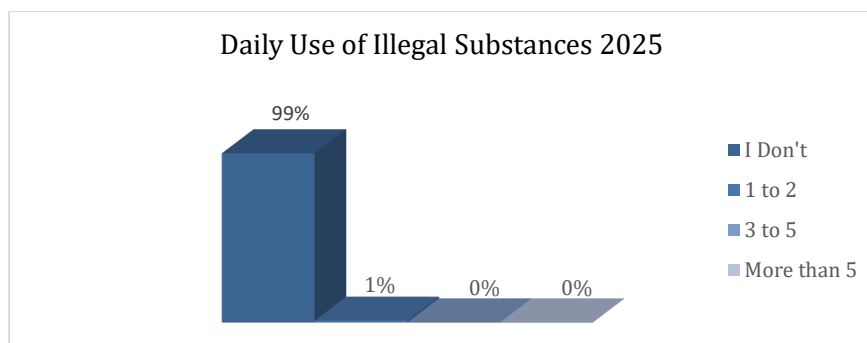
Figure 44



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.

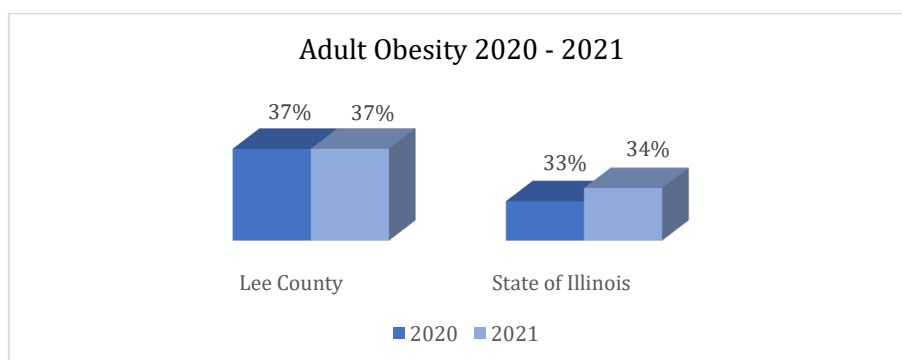
With adults, obesity has far-reaching consequences. Testimony to the Illinois General Assembly indicated that obesity-related illnesses contribute to worker absenteeism, slow workflow, and high worker compensation rates. A Duke University study on the effects of obesity in the workforce noted 13 times 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/m<sup>2</sup> (age-adjusted).

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

Figure 46

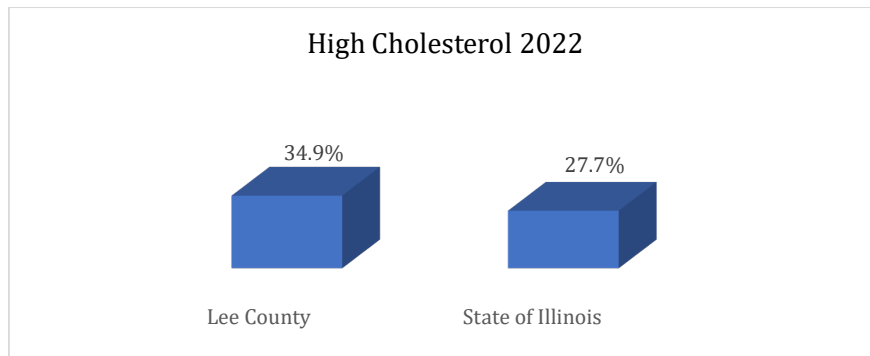


Source: County Health Rankings & Roadmaps

### 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).

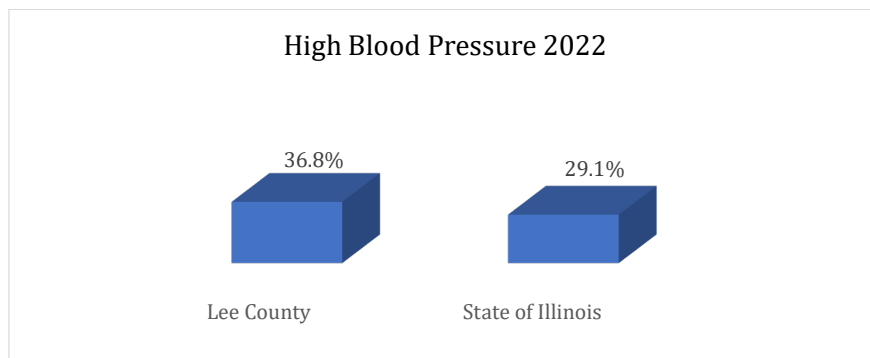
Figure 47



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      |

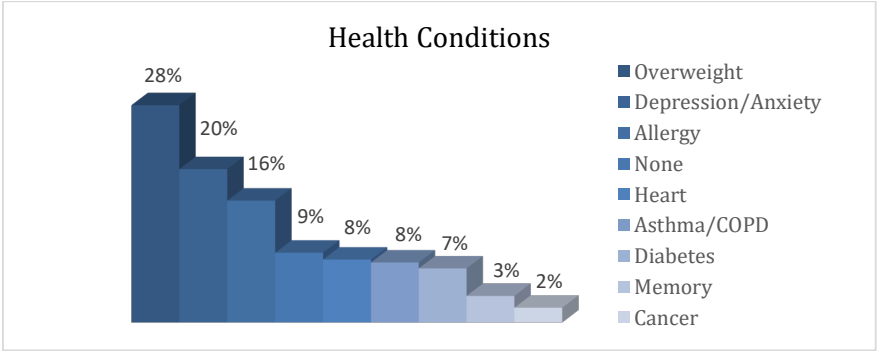
CHAPTER 4: MORBIDITY AND MORTALITY

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

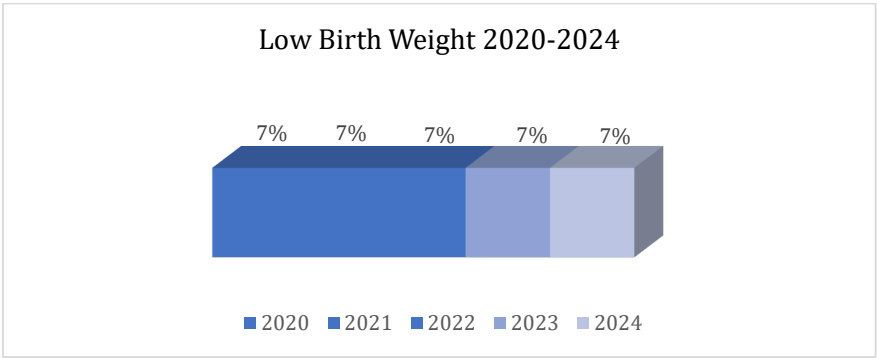
## 4.2 Healthy Babies

*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

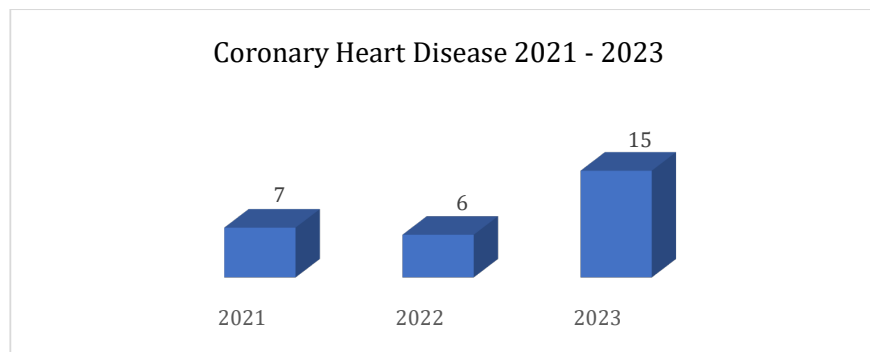
*Importance of the Measure:* Cardiovascular disease encompasses all diseases of the heart and blood vessels, including ischemic (also known as coronary) heart disease, cerebrovascular disease, congestive heart failure, hypertensive disease, and atherosclerosis.

### 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

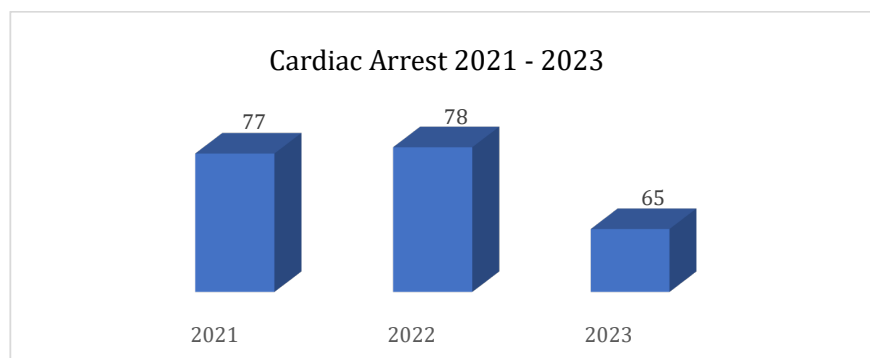


Source: COMPdata Informatics

## 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

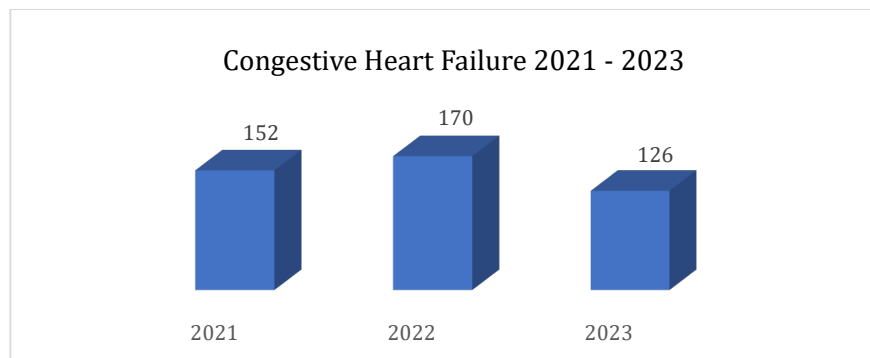


Source: COMPdata Informatics

## 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

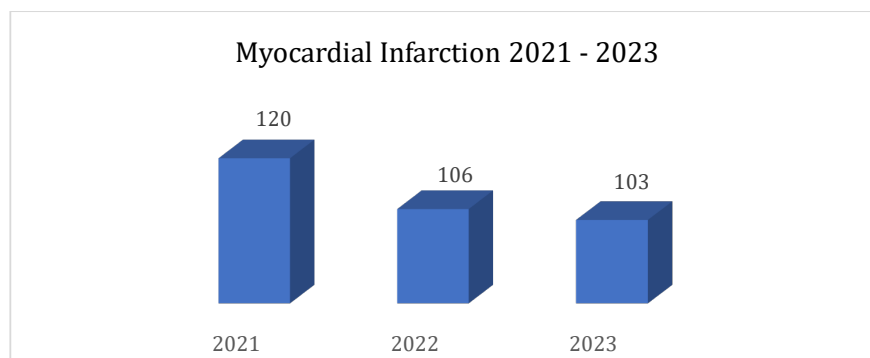


Source: COMPdata Informatics

## 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



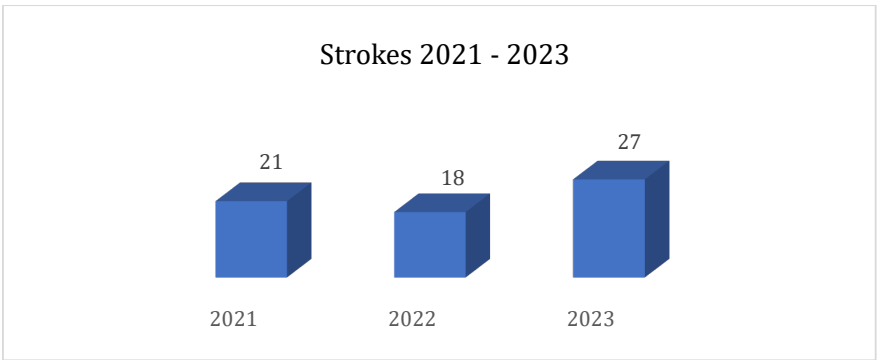
Source: COMPdata Informatics

## 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



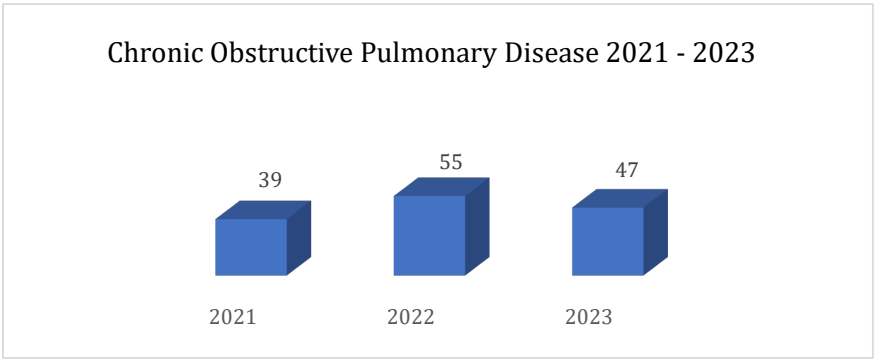
Source: COMPdata Informatics

### 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



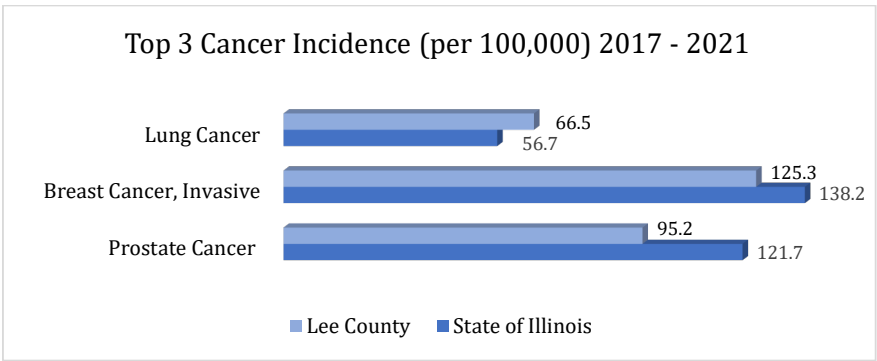
Source: COMPdata Informatics

## 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



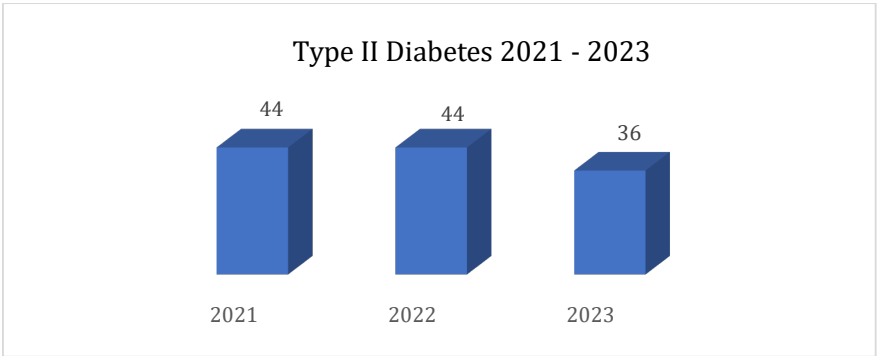
Source: Illinois Department of Public Health

## 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).

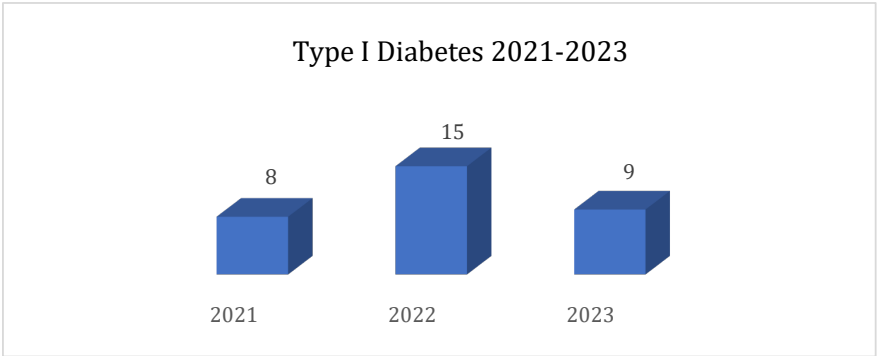
Figure 58



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

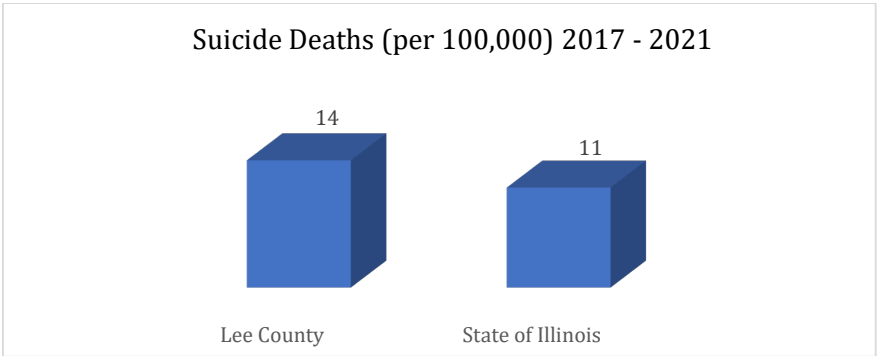
## 4.7 Injuries

*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.

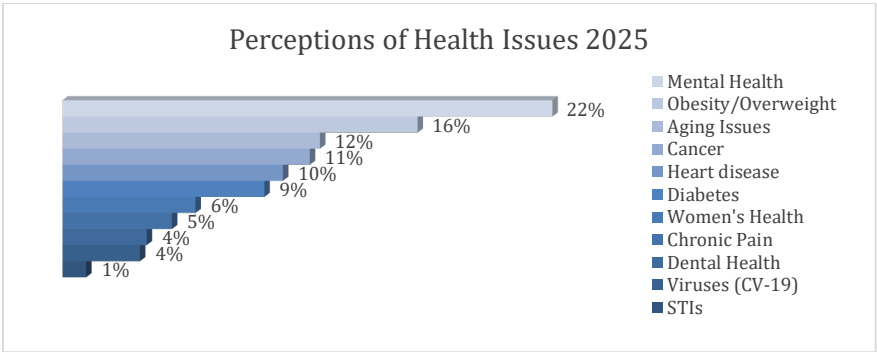
### **5.1 Perceptions of Health Issues**

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

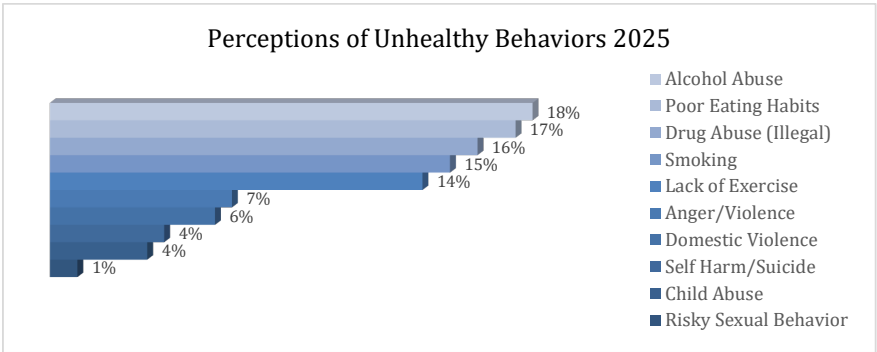


Source: CHNA Survey

## 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



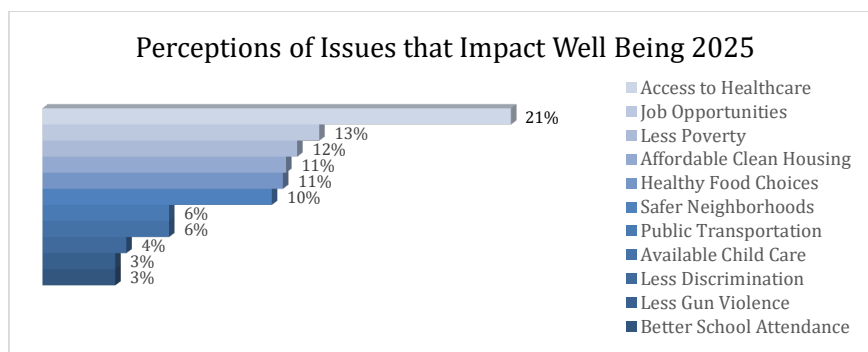
Source: CHNA Survey

## 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**

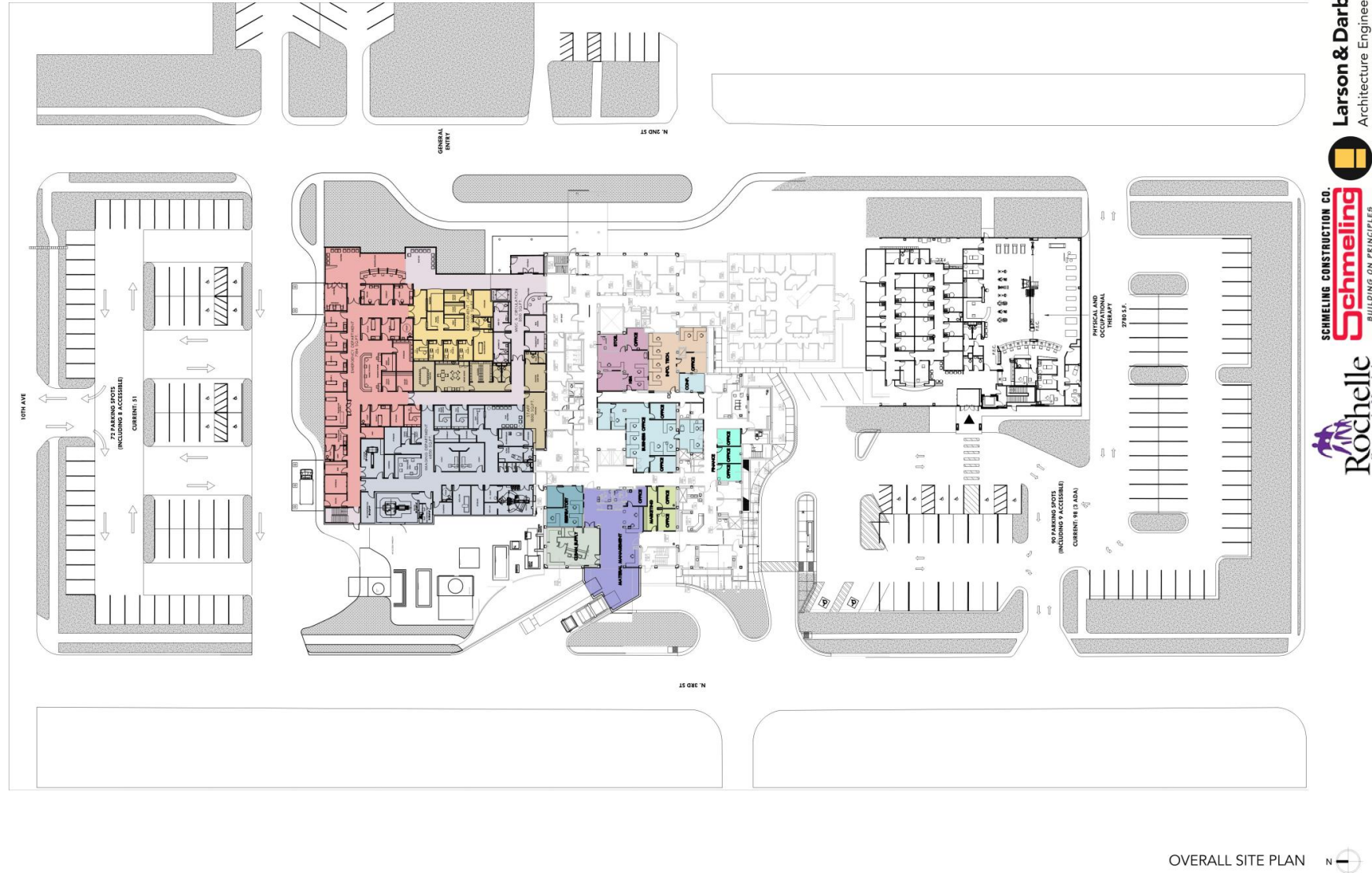
## **BEHAVIORIAL HEALTH – MENTAL HEALTH**

**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**

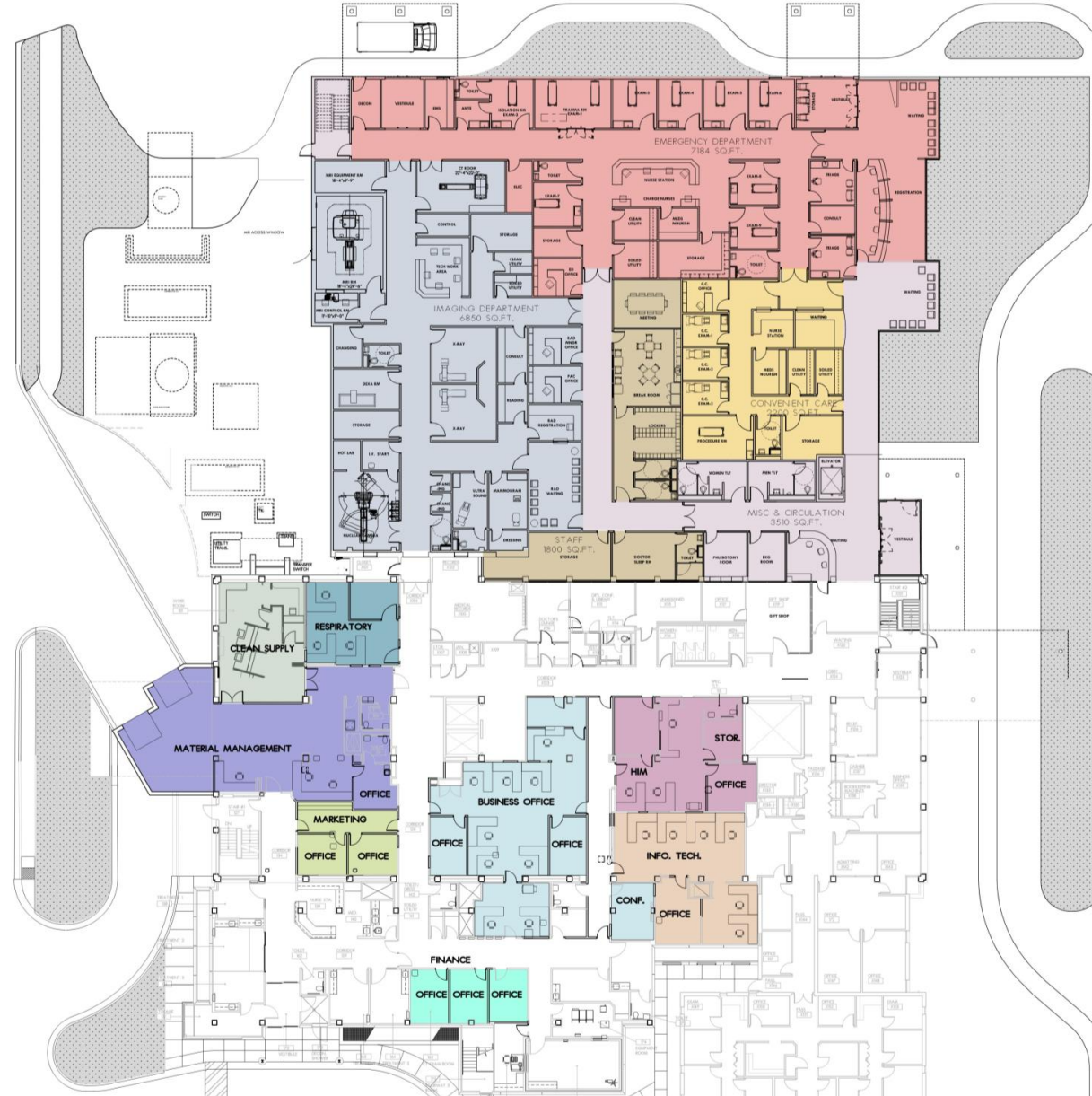
**PRIMARY SOURCE OF HEALTHCARE.** The CHNA survey asked respondents to identify their primary source of healthcare. Four different options were presented: clinic or doctor's office, urgent-care facility, did not seek medical treatment, and emergency department. The most common response for source of 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.



OVERALL SITE PLAN



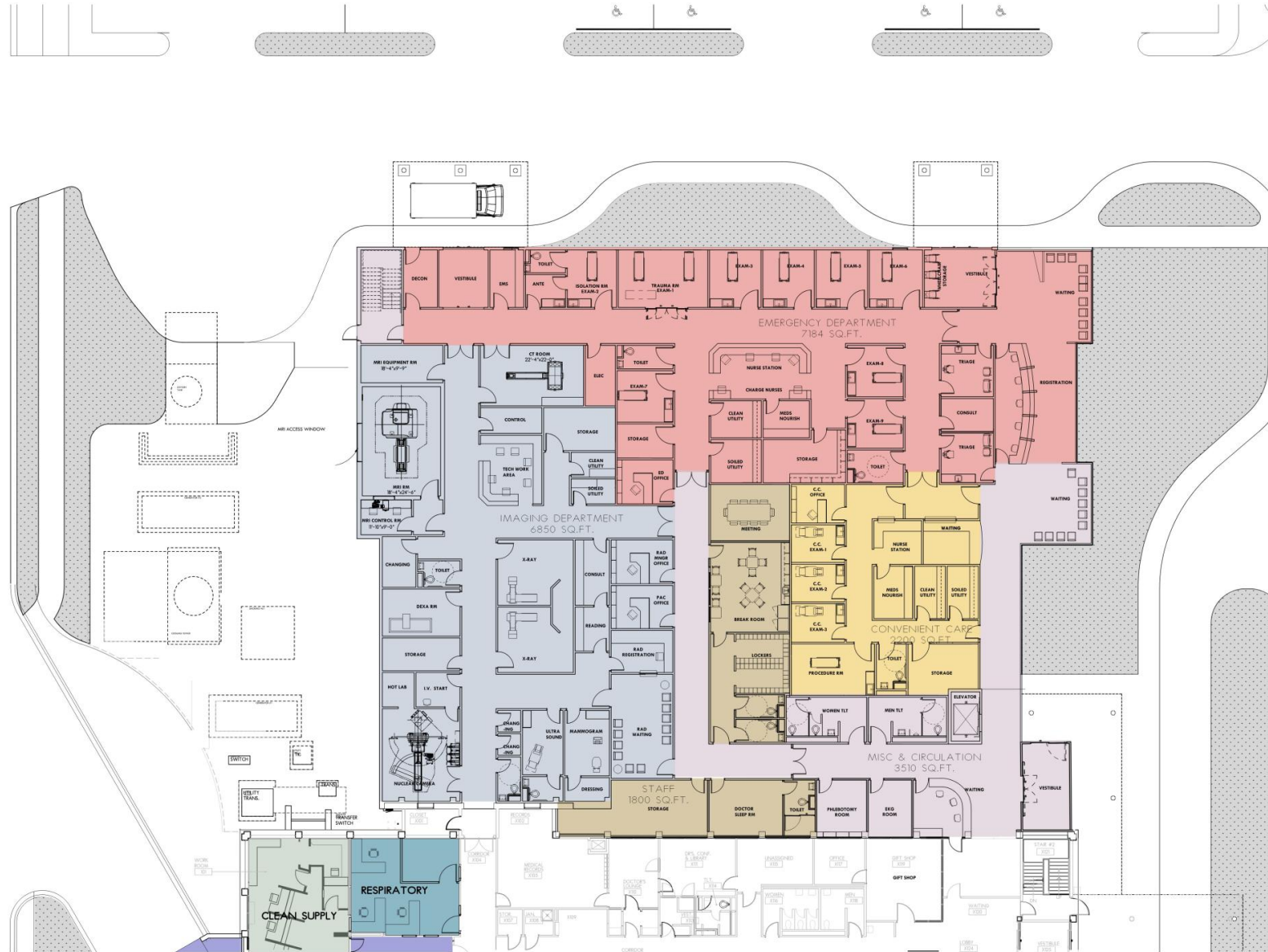




**BASEMENT FLOOR PLAN**  
SCALE: 1/8" = 1'-0"







FIRST FLOOR PLAN - ENLARGED





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.

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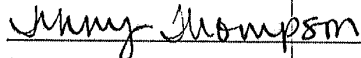
**Securing the Long-Term Viability of the Hospital**

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

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

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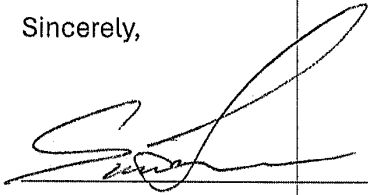
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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sam Tesreau', is written over a horizontal line.

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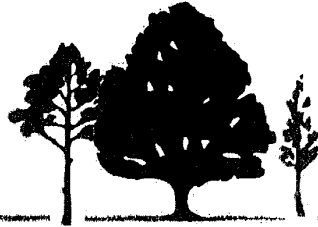
Thank you for your time and consideration of this important matter. Please feel free to reach out to my office with questions by phone at 815-561-3690 or by email at [Fritts@ILHouseGOP.org](mailto:Fritts@ILHouseGOP.org).

Sincerely,

A handwritten signature in black ink that reads "Bradley J. Fritts".

State Representative Bradley J. Fritts  
District 74

SOYBEAN INKS



## *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](mailto:ktracy@rcha.net/815.562.2480)

March 3, 2026

Dear Karen Tracy,

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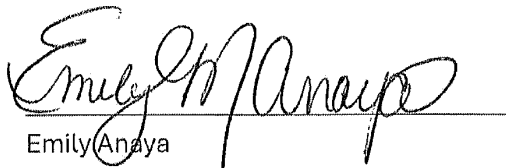
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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

A handwritten signature in black ink, reading "Emily Anaya". The signature is written in a cursive, flowing style. Below the signature is a horizontal line.

Emily Anaya

Executive Director

Rochelle Area Community Foundation

[director@rochellefoundation.org](mailto:director@rochellefoundation.org)



**Rochelle Fire Department**  
**401 5<sup>th</sup> 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](mailto: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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Sincerely,

A handwritten signature in black ink, appearing to read "David Sawlsville".

David Sawlsville  
Fire Chief  
Rochelle Fire Department  
dsawlsville@rochelleil.us

**Karen Tracy**  
**Chief Executive Officer**  
**Rochelle Community Hospital**  
**900 North Second Street**  
**Rochelle, IL 61068**  
**[ktracy@rcha.net](mailto:ktracy@rcha.net)/815.562.2480**

**March 3, 2026**

Dear Karen Tracy,

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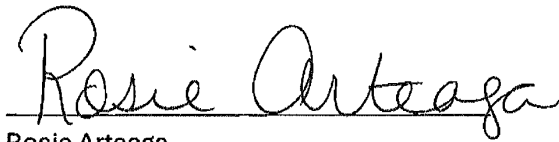
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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

A handwritten signature in cursive script that reads "Rosie Arteaga". The signature is written in black ink and is positioned above a horizontal line.

Rosie Arteaga  
City Council  
City of Rochelle

**Karen Tracy**  
**Chief Executive Officer**  
**Rochelle Community Hospital**  
**900 North Second Street**  
**Rochelle, IL 61068**  
[ktracy@rcha.net](mailto:ktracy@rcha.net)/815.562.2480

**March 3, 2026**

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On behalf of the Rochelle City Council, 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**

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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.

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Updated layouts, expanded treatment areas, and streamlined workflows will improve patient movement through each department, reduce bottlenecks, enhance safety, and

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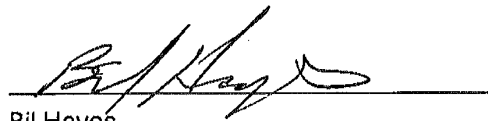
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For a rural community, the stability of the local hospital is vital to the region's health, economy, and resilience. This capital project is not just a facilities improvement—it's a long-term investment in ensuring that Rochelle Community Hospital 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,

A handwritten signature in black ink, appearing to read "Bil Hayes", is written over a horizontal line.

Bil Hayes  
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](mailto:ktracy@rcha.net/815.562.2480)

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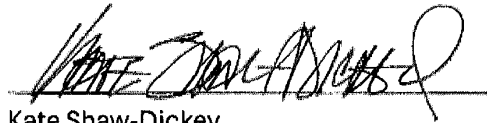
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Sincerely,

A handwritten signature in black ink, appearing to read "Kate Shaw-Dickey", written over a horizontal line.

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/815.562.2480](mailto:ktracy@rcha.net/815.562.2480)

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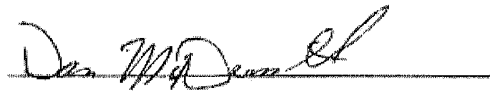
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A handwritten signature in dark ink, appearing to read "Dan McDermott", is written over a horizontal line.

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](mailto:ktracy@rcha.net/815.562.2480)

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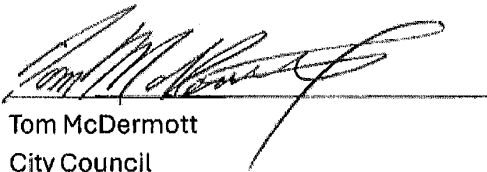
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Sincerely,

A handwritten signature in black ink, appearing to read "Tom McDermott", is written over a horizontal line.

Tom McDermott  
City Council  
City of Rochelle



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](mailto: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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(815)562-8890 24 Hour Hotline

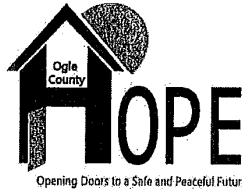


(815)562-4323 Office

[www.hopedv.org](http://www.hopedv.org)

(815)562-5756 Fax





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

(815)562-8890 24 Hour Hotline



(815)562-4323 Office

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**Karen Tracy**  
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**Rochelle Community Hospital**  
**900 North Second Street**  
**Rochelle, IL 61068**  
**[ktracy@rcha.net/815.562.2480](mailto: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,

A handwritten signature in black ink, appearing to read "Sathish", written over a horizontal line.

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,

A handwritten signature in black ink, appearing to read "S. Probst", is written over the typed name.

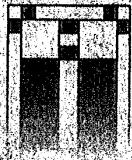
Steve Probst

Rochelle Station Supervisor

Ridge Ambulance Service

sprobst@ridgeems.com

## FLAGG-ROCHELLE



Public  
Library  
District

619 Fourth Avenue • Rochelle, Illinois 61068-1512  
815-562-3431 • Fax: 815-562-3432

**Karen Tracy**  
**Chief Executive Officer**  
**Rochelle Community Hospital**  
**900 North Second Street**  
**Rochelle, IL 61068**  
**[ktracy@rchs.net/815.562.2480](mailto:ktracy@rchs.net/815.562.2480)**

March 4, 2026

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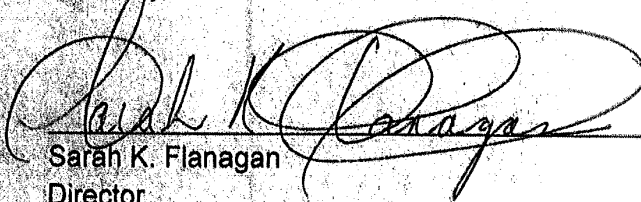
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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

A handwritten signature in dark ink, appearing to read "Sarah K. Flanagan", written over a horizontal line.

Sarah K. Flanagan  
Director

Flagg-Rochelle Public Library  
sarahf@flaggrochellepubliclibrary.org

**Karen Tracy**  
**Chief Executive Officer**  
**Rochelle Community Hospital**  
**900 North Second Street**  
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**[ktracy@rcha.net](mailto:ktracy@rcha.net)/815.562.2480**

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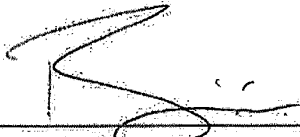
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Sincerely,

A handwritten signature in black ink, appearing to read 'Ben Valdivieso', is written over a horizontal line.

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

March 3, 2026

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420 North 6<sup>th</sup> Street  
Rochelle, IL 61068  
[www.cityofrochelle.net](http://www.cityofrochelle.net)

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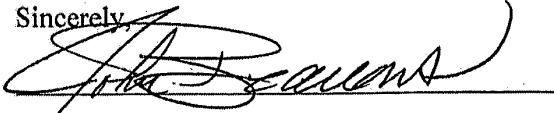
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Sincerely,

A handwritten signature in black ink, appearing to read "John Bearrows", written over a horizontal line.

Mayor John Bearrows  
City of Rochelle  
jbearrows@rochelleil.us



# OSF<sup>®</sup> HEALTHCARE

**Karen Tracy**  
**Chief Executive Officer**  
**Rochelle Community Hospital**  
**900 North Second Street**  
**Rochelle, IL 61068**  
**[ktracy@rcha.net/815.562.2480](mailto:ktracy@rcha.net/815.562.2480)**

**March 3, 2026**

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# OSF<sup>®</sup> HEALTHCARE

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Sincerely,

---

AJ Querciagrossa  
Chief Executive Officer - Western Region  
OSF HealthCare  
[august.j.querciagrossa@osfhealthcare.org](mailto:august.j.querciagrossa@osfhealthcare.org)



Karen Tracy  
Chief Executive Officer  
Rochelle Community Hospital  
900 North Second Street  
Rochelle, IL 61068  
[ktracy@rcha.net](mailto: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.

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**

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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.

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,

A handwritten signature in black ink, appearing to read 'Jason Harper', with a stylized flourish at the end.

Jason Harper  
Superintendent of the Rochelle Schools  
[jharper@rthsd212.org](mailto:jharper@rthsd212.org) / 815-562-4161



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

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---

*Executive Director*  
*Diana King*

*Board Members:*  
*Chet Olson*  
*President*

*Fred Horner*  
*Vice-President*

*Sarah Flanagan*  
*Sec-Treasurer*

*Bobbie Colbert*  
*David Eckhardt*  
*Deb Schiller*  
*Rebecca Fraley*

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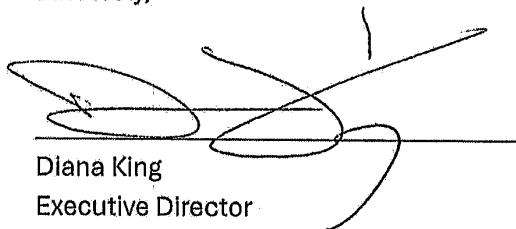
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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

A handwritten signature in black ink, appearing to read 'Diana King', is written over a horizontal line.

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



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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](mailto: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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[www.sinnissippi.org](http://www.sinnissippi.org)

[info@sinnissippi.com](mailto:info@sinnissippi.com)

800-242-7642

Sinnissippi Centers receives local funding including support from 708 Mental Health and 553 Public Health boards and local United Way chapters. Sinnissippi Centers is funded, in part, by the Illinois Department of Human Services. Sinnissippi Centers is accredited by The Joint Commission and is a recipient of the Gold Seal of Approval.





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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.

[www.sinnissippi.org](http://www.sinnissippi.org)

[info@sinnissippi.com](mailto:info@sinnissippi.com)

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**Rochelle Community Hospital**  
**900 North Second Street**  
**Rochelle, IL 61068**  
**[ktracy@rcha.net/815.562.2480](mailto: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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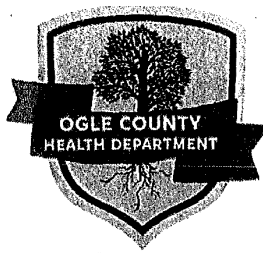
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Thank you for your consideration. Please feel free to contact me if additional information or perspective would be valuable.

Sincerely,

A handwritten signature in black ink, appearing to read 'Greg Gates', written in a cursive style.

Greg Gates  
Executive Director  
Reagan Mass Transit  
[ggates@reaganmtd.org](mailto: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](mailto: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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907 Pines Rd, Oregon, IL 61061 • 510 Lincoln Hwy, Rochelle, IL 61068  
P: 815.562.6976 • F: 815.732.7458 • [health@oglecountyil.gov](mailto:health@oglecountyil.gov)  
[www.health.oglecountyil.gov](http://www.health.oglecountyil.gov)



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

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.

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

\*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<br>2000 x 10 stations =<br>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.

| <u>Dept./Service</u>     | <b>Historical Utilization</b> |       | <b>Projected Utilization</b>   |                                | <b>State Standard to Justify Second Unit</b> | <b>Meet Standard?</b> |
|--------------------------|-------------------------------|-------|--------------------------------|--------------------------------|----------------------------------------------|-----------------------|
|                          | 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.

| <u>Dept./Service</u> | <b>Historical Utilization</b> |              | <b>Projected Utilization</b>   |                                | <b>State Standard</b> | <b>Meet Standard?</b> |
|----------------------|-------------------------------|--------------|--------------------------------|--------------------------------|-----------------------|-----------------------|
|                      | 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;<sup>5</sup>
- (2) The project is necessary to expand diagnostic treatment, ancillary training, or other support services to meet patient service demand;<sup>6</sup> or
- (3) Utilization.<sup>7</sup>
  - 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.

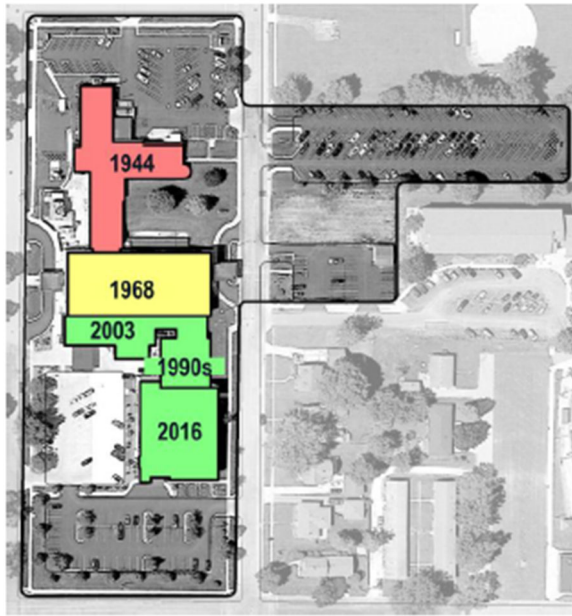
RCH was established in 1913 under the name Lincoln Hospital. The current hospital campus at 900 North Second Street was developed beginning in 1944 and has undergone multiple additions and expansions over the decades, including a 1968 expansion housing the Laboratory and Radiology departments, a 1990s 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.

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<sup>5</sup> 77 Ill. Admin. Code § 1110.270(c)(1).

<sup>6</sup> 77 Ill. Admin. Code § 1110.270(c)(2).

<sup>7</sup> 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.

|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><u>\$48,579,513</u></b> | a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"><li>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</li><li>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.</li></ol>                                                                                                                                                                                                                                                                                                              |
| _____                      | 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: <ol style="list-style-type: none"><li>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.</li><li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate.</li><li>3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time</li></ol> |



|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                            | <p>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.</p> <p>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.</p> <p>5) For any option to lease, a copy of the option, including all terms and conditions.</p> |
| _____                      | 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.                                                                                                                                                                                                                                                                                                                                                                |
| <b><u>\$48,579,513</u></b> | <b>TOTAL FUNDS AVAILABLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

**ROCHELLE COMMUNITY HOSPITAL  
ASSOCIATION AND ITS AFFILIATES**

**CONSOLIDATED FINANCIAL STATEMENTS AND  
SUPPLEMENTARY INFORMATION**

**YEARS ENDED APRIL 30, 2025 AND 2024**



CPAs | CONSULTANTS | WEALTH ADVISORS

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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**

St. Louis, Missouri  
July 29, 2025

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

|                                                                | <u>2025</u>                 | <u>2024</u>                 |
|----------------------------------------------------------------|-----------------------------|-----------------------------|
| <b>ASSETS</b>                                                  |                             |                             |
| <b>CURRENT ASSETS</b>                                          |                             |                             |
| 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                              | <u>1,672,372</u>            | <u>1,415,932</u>            |
| Total Current Assets                                           | 61,553,885                  | 57,652,652                  |
| <b>OTHER ASSETS</b>                                            |                             |                             |
| 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                                  | <u>169,112</u>              | <u>250,225</u>              |
| Total Other Assets                                             | <u>18,530,760</u>           | <u>19,360,433</u>           |
| Total Assets                                                   | <u><u>\$ 80,084,645</u></u> | <u><u>\$ 77,013,085</u></u> |
| <b>LIABILITIES AND NET ASSETS</b>                              |                             |                             |
| <b>CURRENT LIABILITIES</b>                                     |                             |                             |
| 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                               | <u>239,036</u>              | <u>525,036</u>              |
| Total Current Liabilities                                      | 5,569,514                   | 5,240,477                   |
| <b>LONG-TERM LIABILITIES</b>                                   |                             |                             |
| 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                         | <u>2,353,128</u>            | <u>3,944,014</u>            |
| Total Long-Term Liabilities                                    | <u>2,787,706</u>            | <u>4,476,360</u>            |
| Total Liabilities                                              | 8,357,220                   | 9,716,837                   |
| <b>NET ASSETS</b>                                              |                             |                             |
| Net Assets Without Donor Restrictions                          | <u>71,727,425</u>           | <u>67,296,248</u>           |
| Total Liabilities and Net Assets                               | <u><u>\$ 80,084,645</u></u> | <u><u>\$ 77,013,085</u></u> |

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**

|                                                              | <u>2025</u>                 | <u>2024</u>                 |
|--------------------------------------------------------------|-----------------------------|-----------------------------|
| <b>NET ASSETS WITHOUT DONOR RESTRICTIONS</b>                 |                             |                             |
| Operating Revenue:                                           |                             |                             |
| Patient Service Revenue                                      | \$ 52,814,394               | \$ 49,944,866               |
| Other Revenue                                                | 557,938                     | 398,601                     |
| Total Operating Revenue                                      | <u>53,372,332</u>           | <u>50,343,467</u>           |
| 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                                     | <u>51,838,305</u>           | <u>47,286,367</u>           |
| <b>INCOME FROM OPERATIONS</b>                                | 1,534,027                   | 3,057,100                   |
| <b>OTHER INCOME (EXPENSES)</b>                               |                             |                             |
| 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                                           | <u>2,897,150</u>            | <u>3,202,334</u>            |
| <b>EXCESS OF REVENUES OVER EXPENSES</b>                      | 4,431,177                   | 6,259,434                   |
| Net Assets - Beginning of Year                               | <u>67,296,248</u>           | <u>61,036,814</u>           |
| <b>NET ASSETS - END OF YEAR</b>                              | <u><u>\$ 71,727,425</u></u> | <u><u>\$ 67,296,248</u></u> |

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**

|                                                                                               | <u>2025</u>                 | <u>2024</u>                 |
|-----------------------------------------------------------------------------------------------|-----------------------------|-----------------------------|
| <b>CASH FLOWS FROM OPERATING ACTIVITIES</b>                                                   |                             |                             |
| 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                                     | <u>(382,705)</u>            | <u>282,622</u>              |
| Net Cash Provided by Operating Activities                                                     | 7,202,767                   | 7,591,146                   |
| <b>CASH FLOWS FROM INVESTING ACTIVITIES</b>                                                   |                             |                             |
| Purchases of Property and Equipment                                                           | (3,676,863)                 | (2,441,827)                 |
| Change in Temporary Investments and Assets Limited as to Use                                  | <u>(7,057)</u>              | <u>147,390</u>              |
| Net Cash Used by Investing Activities                                                         | (3,683,920)                 | (2,294,437)                 |
| <b>CASH FLOWS FROM FINANCING ACTIVITIES</b>                                                   |                             |                             |
| Payments on Finance Lease Obligations                                                         | (166,737)                   | (141,569)                   |
| Payments on Bonds Payable                                                                     | <u>(1,952,134)</u>          | <u>(525,037)</u>            |
| Net Cash Used by Financing Activities                                                         | (2,118,871)                 | (666,606)                   |
| <b>NET INCREASE IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH</b>                            | 1,399,976                   | 4,630,103                   |
| Cash, Cash Equivalents, and Restricted Cash - Beginning of Year                               | <u>27,052,620</u>           | <u>22,422,517</u>           |
| <b>CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - END OF YEAR</b>                              | <u><u>\$ 28,452,596</u></u> | <u><u>\$ 27,052,620</u></u> |
| <b>SUMMARY OF CASH, CASH EQUIVALENTS, AND RESTRICTED CASH</b>                                 |                             |                             |
| 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                                             | <u><u>\$ 28,022,687</u></u> | <u><u>\$ 27,052,620</u></u> |
| <b>SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION</b>                                       |                             |                             |
| Cash Paid for Interest                                                                        | <u><u>\$ 187,300</u></u>    | <u><u>\$ 168,554</u></u>    |

See accompanying Notes to Consolidated Financial Statements.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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,<br>Held by Trustee | 244,619              | 505,435              |
| Total                                                           | <u>\$ 58,250,009</u> | <u>\$ 54,988,683</u> |

**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 | <u>\$ 244,619</u> | <u>\$ 505,435</u> |

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<br>Temporary Investments | <u>\$ 24,339,339</u> | <u>\$ 22,407,515</u> |

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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                      | <u>\$ 2,184,210</u> | <u>\$ 2,619,939</u> |

**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                       | <u>\$ 17,851,979</u> | <u>\$ 18,620,391</u> |

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.



**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**NOTE 5 BONDS PAYABLE**

Bonds payable consist of the following at April 30:

| <u>Description</u>                                                                                                                                                                                                  | <u>2025</u>                | <u>2024</u>                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| 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.                                                   | <u>2,629,401</u>           | <u>2,868,436</u>           |
| Total                                                                                                                                                                                                               | 2,629,401                  | 4,581,436                  |
| Less: Unamortized Debt Issuance Costs                                                                                                                                                                               | (37,237)                   | (112,386)                  |
| Less: Current Portion                                                                                                                                                                                               | <u>(239,036)</u>           | <u>(525,036)</u>           |
| Long-Term Portion                                                                                                                                                                                                   | <u><u>\$ 2,353,128</u></u> | <u><u>\$ 3,944,014</u></u> |

**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 par, 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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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:

| <u>Year</u> | <u>Amount</u>              |
|-------------|----------------------------|
| 2026        | \$ 239,036                 |
| 2027        | 239,036                    |
| 2028        | 239,036                    |
| 2029        | 239,036                    |
| 2030        | 239,036                    |
| Thereafter  | 1,434,221                  |
| Total       | <u><u>\$ 2,629,401</u></u> |

**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:

| <u>Lease Costs:</u>                 | <u>2025</u>              | <u>2024</u>              |
|-------------------------------------|--------------------------|--------------------------|
| 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                               | <u><u>\$ 258,877</u></u> | <u><u>\$ 250,720</u></u> |

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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<br>Financing Lease Liabilities | \$ 87,443  | \$ -       |
| Right-of-Use Assets Obtained in Exchange for New<br>Operating Lease Liabilities | \$ -       | \$ -       |
| Weighted-Average Years Remaining Lease Term -<br>Financing Leases               | 1.4 Years  | 2.3 Years  |
| Weighted-Average Years Remaining Lease Term -<br>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:

| <u>Year Ending December 31,</u> | <u>Financing<br/>Leases</u> | <u>Operating<br/>Leases</u> |
|---------------------------------|-----------------------------|-----------------------------|
| 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             | <u>\$ 276,291</u>           | <u>\$ 174,884</u>           |

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**NOTE 7 PATIENT SERVICE REVENUE (CONTINUED)**

The opening and closing contract balances were as follows:

|                              | Patient<br>Accounts<br>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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.)

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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.



**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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                                 | <u>100 %</u> | <u>100 %</u> |

**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.

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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       | Clinic Based        | Administration      | Total                |
|                               | Patient Services     | Services            |                     |                      |
| 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                         | <u>\$ 35,897,790</u> | <u>\$ 6,879,921</u> | <u>\$ 9,060,594</u> | <u>\$ 51,838,305</u> |

|                               | 2024                 |                     |                     |                      |
|-------------------------------|----------------------|---------------------|---------------------|----------------------|
|                               | Health Care Services |                     | Support Services    |                      |
|                               | Hospital Based       | Clinic Based        | Administration      | Total                |
|                               | Patient Services     | Services            |                     |                      |
| 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                         | <u>\$ 32,667,155</u> | <u>\$ 6,066,840</u> | <u>\$ 8,552,372</u> | <u>\$ 47,286,367</u> |

**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

**ROCHELLE COMMUNITY HOSPITAL ASSOCIATION AND ITS AFFILIATES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**APRIL 30, 2025 AND 2024**

**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<br>Inputs    | Level 2<br>Inputs | Level 3<br>Inputs | Total<br>Fair Value  |
| Investments:          |                      |                   |                   |                      |
| Mutual Funds          | \$ 24,006,779        | \$ -              | \$ -              | \$ 24,006,779        |
| Deferred Compensation |                      |                   |                   |                      |
| Investments:          |                      |                   |                   |                      |
| Mutual Funds          | 248,504              | -                 | -                 | 248,504              |
| Total                 | <u>\$ 24,255,283</u> | <u>\$ -</u>       | <u>\$ -</u>       | <u>\$ 24,255,283</u> |
| 2024                  |                      |                   |                   |                      |
|                       | Level 1<br>Inputs    | Level 2<br>Inputs | Level 3<br>Inputs | Total<br>Fair Value  |
| Investments:          |                      |                   |                   |                      |
| Mutual Funds          | \$21,877,786         | \$ -              | \$ -              | \$21,877,786         |
| Deferred Compensation |                      |                   |                   |                      |
| Investments:          |                      |                   |                   |                      |
| Mutual Funds          | 151,701              | -                 | -                 | 151,701              |
| Total                 | <u>\$ 22,029,487</u> | <u>\$ -</u>       | <u>\$ -</u>       | <u>\$ 22,029,487</u> |

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<br>Community<br>Hospital<br>Association | Rochelle<br>Community<br>Hospital<br>Foundation | Eliminations | Consolidated  |
|----------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|--------------|---------------|
| <b>ASSETS</b>                                                  |                                                  |                                                 |              |               |
| <b>CURRENT ASSETS</b>                                          |                                                  |                                                 |              |               |
| 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    |
| <b>OTHER ASSETS</b>                                            |                                                  |                                                 |              |               |
| 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 |
| <b>LIABILITIES AND NET ASSETS</b>                              |                                                  |                                                 |              |               |
| <b>CURRENT LIABILITIES</b>                                     |                                                  |                                                 |              |               |
| 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     |
| <b>LONG-TERM LIABILITIES</b>                                   |                                                  |                                                 |              |               |
| 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     |
| <b>NET ASSETS</b>                                              |                                                  |                                                 |              |               |
| 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 |

**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<br>Community<br>Hospital<br>Association | Rochelle<br>Community<br>Hospital<br>Foundation | Eliminations       | Consolidated                |
|----------------------------------------------|--------------------------------------------------|-------------------------------------------------|--------------------|-----------------------------|
| <b>NET ASSETS WITHOUT DONOR RESTRICTIONS</b> |                                                  |                                                 |                    |                             |
| Operating Revenue:                           |                                                  |                                                 |                    |                             |
| Patient Service Revenue                      | \$ 52,814,394                                    | \$ -                                            | \$ -               | \$ 52,814,394               |
| Other Revenue                                | 467,047                                          | 90,891                                          | -                  | 557,938                     |
| Total Operating Revenue                      | <u>53,281,441</u>                                | <u>90,891</u>                                   | <u>-</u>           | <u>53,372,332</u>           |
| 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                     | <u>51,708,742</u>                                | <u>129,563</u>                                  | <u>-</u>           | <u>51,838,305</u>           |
| <b>INCOME FROM OPERATIONS</b>                | 1,572,699                                        | (38,672)                                        | -                  | 1,534,027                   |
| <b>OTHER INCOME (EXPENSES)</b>               |                                                  |                                                 |                    |                             |
| 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                           | <u>2,838,850</u>                                 | <u>58,300</u>                                   | <u>-</u>           | <u>2,897,150</u>            |
| <b>EXCESS OF REVENUES OVER EXPENSES</b>      | 4,411,549                                        | 19,628                                          | -                  | 4,431,177                   |
| Net Assets - Beginning of Year               | <u>66,440,468</u>                                | <u>855,780</u>                                  | <u>-</u>           | <u>67,296,248</u>           |
| <b>NET ASSETS - END OF YEAR</b>              | <u><u>\$ 70,852,017</u></u>                      | <u><u>\$ 875,408</u></u>                        | <u><u>\$ -</u></u> | <u><u>\$ 71,727,425</u></u> |

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

|                                                                                                                       | Rochelle<br>Community<br>Hospital<br>Association | Rochelle<br>Community<br>Hospital<br>Foundation | Eliminations       | Consolidated                |
|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|--------------------|-----------------------------|
| <b>CASH FLOWS FROM OPERATING ACTIVITIES</b>                                                                           |                                                  |                                                 |                    |                             |
| Increase in Net Assets                                                                                                | \$ 4,411,549                                     | \$ 19,628                                       | \$ -               | \$ 4,431,177                |
| Adjustments to Reconcile Increase in Net Assets to Net Cash<br>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<br>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                                                                             | <u>7,159,465</u>                                 | <u>43,302</u>                                   | <u>-</u>           | <u>7,202,767</u>            |
| <b>CASH FLOWS FROM INVESTING ACTIVITIES</b>                                                                           |                                                  |                                                 |                    |                             |
| 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<br>Assets Limited as to Use                                                    | 192,202                                          | (199,259)                                       | -                  | (7,057)                     |
| Net Cash Used by Investing Activities                                                                                 | <u>(3,464,193)</u>                               | <u>(199,259)</u>                                | <u>(20,468)</u>    | <u>(3,683,920)</u>          |
| <b>CASH FLOWS FROM FINANCING ACTIVITIES</b>                                                                           |                                                  |                                                 |                    |                             |
| 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                                                                                 | <u>(2,118,871)</u>                               | <u>(20,468)</u>                                 | <u>20,468</u>      | <u>(2,118,871)</u>          |
| <b>NET INCREASE IN CASH, CASH EQUIVALENTS, AND<br/>RESTRICTED CASH</b>                                                | 1,576,401                                        | (176,425)                                       | -                  | 1,399,976                   |
| Cash, Cash Equivalents, and Restricted Cash - Beginning of Year                                                       | <u>27,019,907</u>                                | <u>32,713</u>                                   | <u>-</u>           | <u>27,052,620</u>           |
| <b>CASH, CASH EQUIVALENTS, AND<br/>RESTRICTED CASH - END OF YEAR</b>                                                  | <u><u>\$ 28,596,308</u></u>                      | <u><u>\$ (143,712)</u></u>                      | <u><u>\$ -</u></u> | <u><u>\$ 28,452,596</u></u> |

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

|                                                                | Rochelle<br>Community<br>Hospital<br>Association | Rochelle<br>Community<br>Hospital<br>Foundation | Eliminations | Consolidated  |
|----------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|--------------|---------------|
| <b>ASSETS</b>                                                  |                                                  |                                                 |              |               |
| <b>CURRENT ASSETS</b>                                          |                                                  |                                                 |              |               |
| 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    |
| <b>OTHER ASSETS</b>                                            |                                                  |                                                 |              |               |
| 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 |
| <b>LIABILITIES AND NET ASSETS</b>                              |                                                  |                                                 |              |               |
| <b>CURRENT LIABILITIES</b>                                     |                                                  |                                                 |              |               |
| 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     |
| <b>LONG-TERM LIABILITIES</b>                                   |                                                  |                                                 |              |               |
| 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     |
| <b>NET ASSETS</b>                                              |                                                  |                                                 |              |               |
| 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 |

**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<br>Community<br>Hospital<br>Association | Rochelle<br>Community<br>Hospital<br>Foundation | Eliminations       | Consolidated                |
|----------------------------------------------|--------------------------------------------------|-------------------------------------------------|--------------------|-----------------------------|
| <b>NET ASSETS WITHOUT DONOR RESTRICTIONS</b> |                                                  |                                                 |                    |                             |
| Operating Revenue:                           |                                                  |                                                 |                    |                             |
| Patient Service Revenue                      | \$ 49,944,866                                    | \$ -                                            | \$ -               | \$ 49,944,866               |
| Other Revenue                                | 328,641                                          | 69,960                                          | -                  | 398,601                     |
| Total Operating Revenue                      | <u>50,273,507</u>                                | <u>69,960</u>                                   | <u>-</u>           | <u>50,343,467</u>           |
| 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                     | <u>47,218,945</u>                                | <u>67,422</u>                                   | <u>-</u>           | <u>47,286,367</u>           |
| <b>INCOME FROM OPERATIONS</b>                | 3,054,562                                        | 2,538                                           | -                  | 3,057,100                   |
| <b>OTHER INCOME (EXPENSES)</b>               |                                                  |                                                 |                    |                             |
| 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                           | <u>3,144,812</u>                                 | <u>57,522</u>                                   | <u>-</u>           | <u>3,202,334</u>            |
| <b>EXCESS OF REVENUES OVER EXPENSES</b>      | 6,199,374                                        | 60,060                                          | -                  | 6,259,434                   |
| Net Assets - Beginning of Year               | <u>60,241,094</u>                                | <u>795,720</u>                                  | <u>-</u>           | <u>61,036,814</u>           |
| <b>NET ASSETS - END OF YEAR</b>              | <u><u>\$ 66,440,468</u></u>                      | <u><u>\$ 855,780</u></u>                        | <u><u>\$ -</u></u> | <u><u>\$ 67,296,248</u></u> |



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

|                                                                                                                       | Rochelle<br>Community<br>Hospital<br>Association | Rochelle<br>Community<br>Hospital<br>Foundation | Eliminations    | Consolidated         |
|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|-----------------|----------------------|
| <b>CASH FLOWS FROM OPERATING ACTIVITIES</b>                                                                           |                                                  |                                                 |                 |                      |
| Increase in Net Assets                                                                                                | \$ 6,199,374                                     | \$ 60,060                                       | \$ -            | \$ 6,259,434         |
| Adjustments to Reconcile Increase in Net Assets to Net Cash<br>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<br>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                                                                             | <u>7,491,537</u>                                 | <u>99,609</u>                                   | <u>-</u>        | <u>7,591,146</u>     |
| <b>CASH FLOWS FROM INVESTING ACTIVITIES</b>                                                                           |                                                  |                                                 |                 |                      |
| 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<br>Assets Limited as to Use                                                    | 234,773                                          | (87,383)                                        | -               | 147,390              |
| Net Cash Used by Investing Activities                                                                                 | <u>(2,227,541)</u>                               | <u>(87,383)</u>                                 | <u>20,487</u>   | <u>(2,294,437)</u>   |
| <b>CASH FLOWS FROM FINANCING ACTIVITIES</b>                                                                           |                                                  |                                                 |                 |                      |
| 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                                                                                 | <u>(666,606)</u>                                 | <u>20,487</u>                                   | <u>(20,487)</u> | <u>(666,606)</u>     |
| <b>NET INCREASE IN CASH, CASH EQUIVALENTS, AND<br/>RESTRICTED CASH</b>                                                | 4,597,390                                        | 32,713                                          | -               | 4,630,103            |
| Cash, Cash Equivalents and Restricted Cash - Beginning of Year                                                        | <u>22,307,347</u>                                | <u>115,170</u>                                  | <u>-</u>        | <u>22,422,517</u>    |
| <b>CASH, CASH EQUIVALENTS, AND<br/>RESTRICTED CASH - END OF YEAR</b>                                                  | <u>\$ 26,904,737</u>                             | <u>\$ 147,883</u>                               | <u>\$ -</u>     | <u>\$ 27,052,620</u> |

**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                | <u>\$ 3,500,417</u> | <u>\$ 2,937,108</u> |

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.



CLA (CliftonLarsonAllen LLP) is a network member of CLA Global. See [CLAGlobal.com/disclaimer](http://CLAGlobal.com/disclaimer). Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC, an SEC-registered investment advisor.

DARIN LAHOOD

16TH DISTRICT, ILLINOIS  
LaHood.house.gov

COMMITTEE ON  
WAYS AND MEANS

HOUSE PERMANENT SELECT  
COMMITTEE ON INTELLIGENCE

SELECT COMMITTEE ON CHINA



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

## Congress of the United States House of Representatives

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

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

### **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**

| <b>COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE</b> |                         |                 |                      |            |                       |            |                      |                    |                       |
|------------------------------------------------------------|-------------------------|-----------------|----------------------|------------|-----------------------|------------|----------------------|--------------------|-----------------------|
| Department<br>(List below)                                 | A                       | B               | C                    | D          | E                     | F          | G                    | H                  | Total Cost<br>(G + H) |
|                                                            | Cost/Square Foot<br>New | Mod.            | Gross Sq. Ft.<br>New | Circ.*     | Gross Sq. Ft.<br>Mod. | Circ.*     | Const. \$<br>(A x C) | Mod. \$<br>(B x E) |                       |
| <b>Clinical</b>                                            | 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             |
|                                                            |                         |                 |                      |            |                       |            |                      |                    |                       |
| <b>Total Clinical</b>                                      | <b>\$671.00</b>         |                 | <b>19,640</b>        | <b>28%</b> |                       | -          | <b>\$13,174,633</b>  |                    | <b>\$13,174,633</b>   |
|                                                            |                         |                 |                      |            |                       |            |                      |                    |                       |
| <b>Non-Clinical</b>                                        |                         |                 |                      |            |                       |            |                      |                    |                       |
| 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           |
|                                                            |                         |                 |                      |            |                       |            |                      |                    |                       |
| <b>Total Non-Clinical</b>                                  | <b>\$1,137</b>          | <b>\$650.00</b> | <b>13,568</b>        | <b>29%</b> | <b>13,970</b>         | <b>33%</b> | <b>\$15,422,395</b>  | <b>\$7,585,080</b> | <b>\$23,007,475</b>   |
|                                                            |                         |                 |                      |            |                       |            |                      |                    |                       |
| <b>TOTALS</b>                                              |                         |                 | <b>33,208</b>        |            | <b>13,970</b>         |            | <b>\$28,597,028</b>  | <b>\$7,585,080</b> | <b>\$36,182,108</b>   |
| * 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.<sup>8</sup>
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 |
|--|---------|---------|

<sup>8</sup> 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        |



May 4, 2026

Mr. John Kniery  
Administrator  
Illinois Health Facilities and Services Review Board  
525 West Jefferson Street, 2<sup>nd</sup> 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.

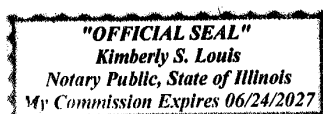
If you have any questions, please do not hesitate to contact me.

Sincerely,

Lori Gutierrez  
Chief Financial Officer  
Rochelle Community Hospital

Subscribed and sworn to before me

This 4 day of May, 2026

  
Notary Public

**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.

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