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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter Social Security numbers on this form as it may be made public By law, the IRS generally cannot redact the information on the form

▶ Information about Form 990 and its instructions is at www.IRS.gov/form990

OMB No 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning 07-01-2013 , 2013, and ending 06-30-2014

B Check if applicable
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
COOPERSTOWN MEDICAL CENTER

Doing Business As

Number and street (or P O box if mail is not delivered to street address) | Room/suite
1200 ROBERTS AVENUE NE

City or town, state or province, country, and ZIP or foreign postal code
COOPERSTOWN, ND 58425

D Employer identification number
45-0227753

E Telephone number
(701) 797-2221

G Gross receipts $ 4,816,074

F Name and address of principal officer
BARBARA ANDERSON
1200 ROBERTS AVENUE NE
COOPERSTOWN, ND 58425

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW COOPERMC COM

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1946

M State of legal domicile ND

Part I Summary

1 Briefly describe the organization's mission or most significant activities
PROVIDE HEALTH CARE SERVICES TO THE RESIDENTS INCLUDING THE ELDERLY IN THE COOPERSTOWN, NORTH DAKOTA AND SURROUNDING COMMUNITIES REGARDLESS OF THE ABILITY TO PAY

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets

Activities & Governance

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	4
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	4
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	**5**	72
6	Total number of volunteers (estimate if necessary)	**6**	70
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	0
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	0

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	250,585	58,102
9	Program service revenue (Part VIII, line 2g)	4,421,393	4,331,223
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	54	-32,746
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	9,959	4,200
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	4,681,991	4,360,779
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	0	3,696
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	2,752,085	2,136,280
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	1,937,712	2,253,619
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	4,689,797	4,393,595
19	Revenue less expenses Subtract line 18 from line 12	-7,806	-32,816

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	2,537,221	2,242,094
21	Total liabilities (Part X, line 26)	4,091,268	3,828,960
22	Net assets or fund balances Subtract line 21 from line 20	-1,554,047	-1,586,866

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here

****** | 2015-05-14
Signature of officer | Date

BARBARA ANDERSON CHIEF FINANCIAL OFFICER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
TIM A RITTER CPA		2015-05-14		P00732856

Firm's name ▶ WIPFLI LLP | Firm's EIN ▶ 39-0758449

Firm's address ▶ 7601 FRANCE AVENUE SOUTH SUITE 400
MINNEAPOLIS, MN 55435 | Phone no (952) 548-3400

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III . . . . . ☐

1 Briefly describe the organization's mission

COOPERSTOWN MEDICAL CENTER IS DEDICATED TO PROVIDING HIGH QUALITY HEALTHCARE SERVICES IN A PERSONALIZED, COMPASSIONATE, AND PROFESSIONAL MANNER

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☑ No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a (Code) (Expenses $ 3,605,988 including grants of $ 3,696) (Revenue $ 4,331,223)

AN 18-BED CRITICAL ACCESS HOSPITAL IS PRIVATELY LOCATED ON THE SECOND FLOOR OF THE FACILITY HELPING TO RELIEVE THE ADDED STRESS OF EXTENDED TRAVEL, THE ORGANIZATION IS ABLE TO PROVIDE LOCALLY MANY OF THE SERVICES FOUND AT LARGE HOSPITALS THROUGH STRONG AFFILIATIONS WITH MAJOR MEDICAL ORGANIZATIONS, COOPERSTOWN MEDICAL CENTER IS ABLE TO PROVIDE 24-HOUR EMERGENCY SERVICES, OCCUPATIONAL THERAPY, X-RAY AND LABORATORY SERVICES, ELECTROCARDIOGRAPHY, RESPIRATORY THERAPY, INCONTINENCE MANAGEMENT, THERAPY, PHYSICAL THERAPY, SPEECH THERAPY, CARDIAC MONITORING/TELEMETRY, CHEMOTHERAPY, SWING BED, AND HOSPICE CARE THE HOSPITAL HAD 1,356 TOTAL INPATIENT DAYS

4b (Code) (Expenses $ including grants of $) (Revenue $)

4c (Code) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O)
(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶ 3,605,988

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9	Yes	
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI.*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	

Part IV Checklist of Required Schedules *(continued)*

21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**		No
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If so, complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**		No
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	1a	19		
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c			
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	72		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b		Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .	3a			No
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .	3b			
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for Form TD F 90-22 1, Report of Foreign Bank and Financial Accounts				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .	5a			No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	6a			No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .	7f			No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O	13a			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .	14b			

Part VI **Governance, Management, and Disclosure** *For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI . . . . . ☑

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	4		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	4		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	**2**			No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? .	**3**			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	**4**			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .	**5**			No
6	Did the organization have members or stockholders?	**6**			No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	**7a**			No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	**7b**			No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	**8a**		Yes	
b	Each committee with authority to act on behalf of the governing body?	**8b**		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	**9**			No

Section B. Policies (*This Section B requests information about policies not required by the Internal Revenue Code.*)

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	**10a**		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	**10b**		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	**11a**		No
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	**12a**	Yes	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	**12b**	Yes	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	**12c**	Yes	
13	Did the organization have a written whistleblower policy?	**13**	Yes	
14	Did the organization have a written document retention and destruction policy?	**14**	Yes	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	**15a**	Yes	
b	Other officers or key employees of the organization	**15b**	Yes	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	**16a**		No
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	**16b**		

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed ▶

18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization

▶BARBARA ANDERSON 1200 ROBERTS AVE NE
COOPERSTOWN, ND 58425 (701) 797-2221

Part VII Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII . . . . . ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed Report compensation for the calendar year ending with or within the organization's tax year

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid
- List all of the organization's **current** key employees, if any See instructions for definition of "key employee "
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) ROB RESSLER DIRECTOR	1 00	X						0	0	0
(2) BARRY GETZ CHAIRMAN	1 00	X		X				0	0	0
(3) JAYNE OTT SECRETARY	1 00 1 00	X		X				0	0	0
(4) DONNA EVERS TREASURER	1 00 1 00	X		X				0	0	0
(5) GREGORY STOMP CEO (THRU AUGUST)	16 00 1 00			X				19,108	0	277
(6) NICOLE JOHNSON CEO/ADMINISTRATOR	16 00			X				0	0	0
(7) KENNETH SMITH CFO (THRU DECEMBER)	40 00			X				73,622	0	4,978
(8) BARBARA ANDERSON CFO	40 00			X				0	0	0
(9) KEVIN JACOBSON NURSE PRACTITIONER	32 00					X		135,094	0	4,277
(10) MOHAN KARKI PHYSICIAN	40 00					X		219,065	0	7,246
(11) BRIAN TWETE NURSE PRACTITIONER	32 00					X		156,896	0	9,513
(12) TRENT BITZ NURSE PRACTITIONER	32 00					X		179,242	0	2,622

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
1b **Sub-Total** ▶										
c **Total from continuation sheets to Part VII, Section A** ▶										
d **Total (add lines 1b and 1c)** ▶								783,027	0	28,913

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 4

			Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	**3**		No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	**4**	Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	**5**		No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization Report compensation for the calendar year ending with or within the organization's tax year

(A) Name and business address	(B) Description of services	(C) Compensation

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 0

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII . . . . . ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns . .	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations . . .	1d	20,000			
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	38,102			
	g	Noncash contributions included in lines 1a-1f $					
	h	**Total.** Add lines 1a-1f . . . . . ▶		58,102			
Program Service Revenue			Business Code				
	2a	NET PATIENT & RES REV	623000	3,660,966	3,660,966		
	b	OPERATING SUBSIDY	623000	351,763	351,763		
	c	ASSISTED LIVING RENTAL	623000	198,399	198,399		
	d	OTHER PATIENT REVENUE	623000	63,040	63,040		
	e	CARE CENTER REVENUE	623000	48,490	48,490		
	f	All other program service revenue		8,565	8,565		
	g	**Total.** Add lines 2a–2f . . . . . ▶		4,331,223			
	3	Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		41			41
	4	Income from investment of tax-exempt bond proceeds . . ▶					
	5	Royalties . . . . . ▶					
			(i) Real / (ii) Personal				
	6a	Gross rents	424,548 /				
	b	Less rental expenses	422,508 /				
	c	Rental income or (loss)	2,040 /				
	d	Net rental income or (loss) . . . . . ▶		2,040			2,040
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	/				
	b	Less cost or other basis and sales expenses	/ 32,787				
	c	Gain or (loss)	/ -32,787				
	d	Net gain or (loss) . . . . . ▶		-32,787			-32,787
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . a					
	b	Less direct expenses . . . b					
	c	Net income or (loss) from fundraising events . . ▶					
	9a	Gross income from gaming activities See Part IV, line 19 . . . a					
	b	Less direct expenses . . . b					
	c	Net income or (loss) from gaming activities . . ▶					
	10a	Gross sales of inventory, less returns and allowances . a					
	b	Less cost of goods sold . . b					
	c	Net income or (loss) from sales of inventory . . ▶					
Other Revenue		Miscellaneous Revenue	Business Code				
	11a						
	b						
	c						
	d	All other revenue		2,160			2,160
	e	**Total.** Add lines 11a–11d . . . . . ▶		2,160			
	12	**Total revenue.** See Instructions . . . . . ▶		4,360,779	4,331,223	0	-28,546

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns All other organizations must complete column (A)

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☑

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States See Part IV, line 21	3,696	3,696		
2 Grants and other assistance to individuals in the United States See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	69,354	58,950	10,404	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	1,873,919	1,592,566	281,353	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	25,220	21,437	3,783	
9 Other employee benefits	36,166	30,741	5,425	
10 Payroll taxes	131,621	111,878	19,743	
11 Fees for services (non-employees)				
a Management				
b Legal	3,049		3,049	
c Accounting	51,768		51,768	
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	1,053,557	733,400	320,157	
12 Advertising and promotion	8,204	4,837	3,367	
13 Office expenses	143,648	87,973	55,675	
14 Information technology	85,284	85,284		
15 Royalties . .				
16 Occupancy	117,256	114,747	2,509	
17 Travel	24,740	21,150	3,590	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	6,148	4,626	1,522	
20 Interest	51,692	51,692		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	89,670	89,670		
23 Insurance	42,968	42,968		
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a DRUG EXPENSE	153,848	153,848		
b BAD DEBT EXPENSE	142,732	142,732		
c MEDICAL SUPPLIES	133,600	133,600		
d LOSS ON REFINANCING	16,846	16,846		
e All other expenses	128,609	103,347	25,262	
25 **Total functional expenses.** Add lines 1 through 24e	4,393,595	3,605,988	787,607	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X . . . . . ☑

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		0	1	12,807
	2	Savings and temporary cash investments		14,624	2	91,928
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		1,106,897	4	978,512
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		74,273	8	68,074
	9	Prepaid expenses and deferred charges		52,257	9	45,629
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 7,964,890			
	b	Less accumulated depreciation	10b 6,938,126	1,269,238	10c	1,026,764
	11	Investments—publicly traded securities			11	
	12	Investments—other securities See Part IV, line 11			12	
	13	Investments—program-related See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets See Part IV, line 11		19,932	15	18,380
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		2,537,221	16	2,242,094
Liabilities	17	Accounts payable and accrued expenses		1,251,901	17	1,076,914
	18	Grants payable			18	
	19	Deferred revenue		35,209	19	0
	20	Tax-exempt bond liabilities		1,354,360	20	2,050,979
	21	Escrow or custodial account liability Complete Part IV of Schedule D		12,800	21	12,600
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties		924,932	23	341,541
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D		512,066	25	346,926
	26	**Total liabilities.** Add lines 17 through 25		4,091,268	26	3,828,960
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		-1,554,047	27	-1,586,866
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		-1,554,047	33	-1,586,866
	34	Total liabilities and net assets/fund balances		2,537,221	34	2,242,094

Part XI Reconcilliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI . . . . . ☑

1	Total revenue (must equal Part VIII, column (A), line 12)	1	4,360,779
2	Total expenses (must equal Part IX, column (A), line 25)	2	4,393,595
3	Revenue less expenses Subtract line 2 from line 1	3	-32,816
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	-1,554,047
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-3
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-1,586,866

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII . . . . . ☑

			Yes	No
1	Accounting method used to prepare the Form 990 ☐ Cash ☑ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		No
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**
▶ **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COOPERSTOWN MEDICAL CENTER

Employer identification number
45-0227753

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is (For lines 1 through 11, check only one box)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E)

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)

9 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

10 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2)

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

	Yes	No
(i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? **11g(i)**		
(ii) A family member of a person described in (i) above? **11g(ii)**		
(iii) A 35% controlled entity of a person described in (i) or (ii) above? **11g(iii)**		

h Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document?		(v) Did you notify the organization in col (i) of your support?		(vi) Is the organization in col (i) organized in the U S ?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
Total									

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
11 **Total support** (Add lines 7 through 10)						

12 Gross receipts from related activities, etc (see instructions) **12**

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and **stop here** . . . . . ▶☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2012 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

b **33 1/3% support test—2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

17a **10%-facts-and-circumstances test—2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶☐

b **10%-facts-and-circumstances test—2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and **stop here** ▶☐

Section C. Computation of Public Support Percentage

15	Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2012 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2012** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2013.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

b **33 1/3% support tests—2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test		
Return Reference	Explanation	

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b
▶ Attach to Form 990. ▶ See separate instructions. ▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COOPERSTOWN MEDICAL CENTER

Employer identification number
45-0227753

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply)
☐ Preservation of land for public use (e g , recreation or education) ☐ Preservation of an historically important land area
☐ Protection of natural habitat ☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

		Held at the End of the Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)

- a ☐ Public exhibition
- b ☐ Scholarly research
- c ☐ Preservation for future generations
- d ☐ Loan or exchange programs
- e ☐ Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☑ No

b If "Yes," explain the arrangement in Part XIII and complete the following table

		Amount
c	Beginning balance	1c
d	Additions during the year	1d
e	Distributions during the year	1e
f	Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21? ☑ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII . . . . . ☑

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

		(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a	Beginning of year balance					
b	Contributions					
c	Net investment earnings, gains, and losses					
d	Grants or scholarships					
e	Other expenditures for facilities and programs					
f	Administrative expenses					
g	End of year balance					

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

- a Board designated or quasi-endowment ▶
- b Permanent endowment ▶
- c Temporarily restricted endowment ▶

The percentages in lines 2a, 2b, and 2c should equal 100%

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

		Yes	No
(i) unrelated organizations	3a(i)		
(ii) related organizations	3a(ii)		
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		133,277		133,277
b Buildings		6,133,217	5,441,072	692,145
c Leasehold improvements				
d Equipment		1,698,396	1,497,054	201,342
e Other				
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				1,026,764

Part VII **Investments—Other Securities.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
Other		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶		

Part VIII **Investments—Program Related.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶		

Part IX **Other Assets.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11d See Form 990, Part X, line 15

(a) Description	(b) Book value
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶	

Part X **Other Liabilities.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1 (a) Description of liability	(b) Book value
Federal income taxes	
CAPITAL LEASE OBLIGATIONS	27,115
DUE TO THIRD PARTY REIMBURSEMENT PROGRAMS	319,811
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	346,926

2. Liability for uncertain tax positions In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740) Check here if the text of the footnote has been provided in Part XIII ☑

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	4,623,709
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII)	2d			
e	Add lines **2a** through **2d**			2e	0
3	Subtract line **2e** from line **1**			3	4,623,709
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII)	4b	-262,930		
c	Add lines **4a** and **4b**			4c	-262,930
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	4,360,779

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return. Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	4,656,525
2	Amounts included on line 1 but not on Form 990, Part IX, line 25				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII)	2d	422,508		
e	Add lines **2a** through **2d**			2e	422,508
3	Subtract line **2e** from line **1**			3	4,234,017
4	Amounts included on Form 990, Part IX, line 25, but not on line **1:**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII)	4b	159,578		
c	Add lines **4a** and **4b**			4c	159,578
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	4,393,595

Part XIII Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b Also complete this part to provide any additional information

Return Reference	Explanation
PART IV, LINE 2B	THE ORGANIZATION HOLDS TENANT SECURITY DEPOSIT FUNDS IN TRUST FOR RESIDENTS
PART X, LINE 2	IN ORDER TO ACCOUNT FOR ANY UNCERTAIN TAX POSITIONS, THE ORGANIZATION DETERMINES WHETHER IT IS MORE LIKELY THAN NOT THAT A TAX POSITION WILL BE SUSTAINED UPON EXAMINATION OF THE TECHNICAL MERITS OF THE POSITION, ASSUMING THE TAXING AUTHORITY HAS FULL KNOWLEDGE OF ALL INFORMATION IF THE TAX POSITION DOES NOT MEET THE MORE-LIKELY-THAN-NOT RECOGNITION THRESHOLD, THE BENEFIT OF THE TAX POSITION IS NOT RECOGNIZED IN THE FINANCIAL STATEMENTS THE ORGANIZATION HAS NOT RECORDED ANY ASSETS OR LIABILITIES RELATED TO UNCERTAIN TAX POSITIONS OR UNRECOGNIZED TAX BENEFITS AS OF JUNE 30, 2014 OR 2013 THE ORGANIZATION'S FEDERAL AND STATE RETURNS FOR TAX YEARS 2010 AND BEYOND REMAIN SUBJECT TO EXAMINATION BY MAJOR TAX JURISDICTIONS
PART XI, LINE 4B - OTHER ADJUSTMENTS	RENTAL EXPENSES -422,508 BAD DEBT EXPENSE 142,732 LOSS ON REFINANCING 16,846
PART XII, LINE 2D - OTHER ADJUSTMENTS	RENTAL EXPENSES 422,508
PART XII, LINE 4B - OTHER ADJUSTMENTS	BAD DEBT EXPENSES 142,732 LOSS ON REFINANCING 16,846

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493135005455

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COOPERSTOWN MEDICAL CENTER

Employer identification number
45-0227753

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for *free* care ☐ 100% ☑ 150% ☐ 200% ☐ Other _____ %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care ☐ 200% ☑ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %	3b	Yes	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		No
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a		No
b	If "Yes," did the organization make it available to the public?	6b		
	Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			49,800	31,755	18,045	0 420 %
b Medicaid (from Worksheet 3, column a)			406,257	351,528	54,729	1 290 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			456,057	383,283	72,774	1 710 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			407	93	314	0 010 %
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)			388,008	277,266	110,742	2 610 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			388,415	277,359	111,056	2 620 %
k **Total.** Add lines 7d and 7j			844,472	660,642	183,830	4 330 %

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 **Total**						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?	1		No
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2 114,554		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 34,366		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	2,259,091
6	Enter Medicare allowable costs of care relating to payments on line 5	6	2,584,783
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-325,692
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Yes	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year? 1

	Name, address, primary website address, and state license number	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group COOPERSTOWN MEDICAL CENTER

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	**1**	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a CHNA 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**3**	Yes	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	**4**		No
5	Did the hospital facility make its CHNA report widely available to the public?	**5**	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) SEE DESCRIPTION			
b	☐ Other website (list url)			
c	☐ Available upon request from the hospital facility			
d	☑ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year)			
a	☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	☑ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide plan			
d	☐ Participation in the execution of a community-wide plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	☑ Prioritization of health needs in its community			
h	☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☑ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	**7**		No
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**8a**		No
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	**8b**		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy		Yes	No
9 Did the hospital facility have in place during the tax year a written financial assistance policy that Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	**9**	Yes	
10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	**10**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for free care 150 000000000000% If "No," explain in Part VI the criteria the hospital facility used			
11 Used FPG to determine eligibility for providing *discounted* care?	**11**	Yes	
If "Yes," indicate the FPG family income limit for eligibility for discounted care 250 000000000000% If "No," explain in Part VI the criteria the hospital facility used			
12 Explained the basis for calculating amounts charged to patients?	**12**	Yes	
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☑ Income level			
b ☑ Asset level			
c ☑ Medical indigency			
d ☑ Insurance status			
e ☑ Uninsured discount			
f ☐ Medicaid/Medicare			
g ☑ State regulation			
h ☐ Residency			
i ☐ Other (describe in Part VI)			
13 Explained the method for applying for financial assistance?	**13**	Yes	
14 Included measures to publicize the policy within the community served by the hospital facility?	**14**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted on the hospital facility's website			
b ☑ The policy was attached to billing invoices			
c ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☑ The policy was provided, in writing, to patients on admission to the hospital facility			
f ☐ The policy was available upon request			
g ☐ Other (describe in Part VI)			
Billing and Collections			
15 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	**15**	Yes	
16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a ☑ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other similar actions (describe in Section C)			
17 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	**17**	Yes	
If "Yes," check all actions in which the hospital facility or a third party engaged			
a ☑ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other similar actions (describe in Section C)			

Part V Facility Information *(continued)*

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply)

- **a** ☑ Notified individuals of the financial assistance policy on admission
- **b** ☑ Notified individuals of the financial assistance policy prior to discharge
- **c** ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**19**	Yes	
If "No," indicate why			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility's policy was not in writing			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care			
a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d ☑ Other (describe in Part VI)			
21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**21**		No
If "Yes," explain in Part VI			
22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**22**		No
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
See Additional Data Table	

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

	Name and address	Type of Facility (describe)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Part VI Supplemental Information

Provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc)

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

Form and Line Reference	Explanation
PART I, LINE 7	THE ORGANIZATION USES A COST TO CHARGE METHODOLOGY AS DETERMINED BY THE MEDICARE COST REPORT

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN (F)	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS $ 142,732

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	THE ORGANIZATION PARTICIPATES IN COMMUNITY BUILDING ACTIVITIES, HOWEVER, THE ACTIVITIES ARE TOO DIFFICULT TO QUANTIFY AND ARE NOT TRACKED THE ORGANIZATION OFFERED WELLNESS SCREENINGS AT NO COST TO THE PUBLIC TO ASSESS HEALTH NEEDS THE ORGANIZATION ALSO OFFERED A COMMUNITY WEIGHT LOSS PROGRAM AND WELLNESS LUNCHEONS

Form and Line Reference	Explanation
PART III, LINE 2	THIS AMOUNT IS CALCULATED BY MULTIPLYING THE TOTAL CHARGES FOR SERVICES WRITTEN OFF AS BAD DEBT BY THE COST TO CHARGE RATIO

Form and Line Reference	Explanation
PART III, LINE 3	THE AMOUNT OF BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY FINANCIAL ASSISTANCE POLICY IS DETERMINED BY THE ORGANIZATION USING INFORMATION AVAILABLE TO MAKE AN EDUCATED ESTIMATE

Form and Line Reference	Explanation
PART III, LINE 4	THE ORGANIZATION USES THE COST TO CHARGE METHODOLOGY TO DETERMINE BAD DEBT THE ORGANIZATION DOES NOT HAVE A FOOTNOTE TO THE ORGANIZATION'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSE THEY DO HAVE A FOOTNOTE ON THE PATIENT ACCOUNTS RECEIVABLE AND CREDIT POLICY, NOTED BELOW PATIENT ACCOUNTS RECEIVABLE AND CREDIT POLICY -IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, THE ORGANIZATION ANALYZES PAST RESULTS AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR DOUBTFUL ACCOUNTS MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS SPECIFICALLY, FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE ORGANIZATION ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR DOUBTFUL ACCOUNTS FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE ORGANIZATION RECORDS A SIGNIFICANT PROVISION FOR DOUBTFUL ACCOUNTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS THE ORGANIZATION'S ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR SELF-PAY PATIENTS DECREASED FROM 66% OF SELF-PAY PATIENT'S ACCOUNTS RECEIVABLE AT JUNE 30, 2013 TO 59% OF SELF-PAY PATIENT'S ACCOUNTS RECEIVABLE AT JUNE 30, 2014 THE ORGANIZATION'S WRITE-OFFS OF PATIENT ACCOUNTS RECEIVABLES, NET OF RECOVERIES, INCREASED FROM $46,603 IN 2013 TO $193,554 IN 2014 AS THE ORGANIZATION UNDERTOOK AN EFFORT TO CLEAN UP OLD RECEIVABLES IN ADDITION, DURING 2014 THE ORGANIZATION WROTE-OFF APPROXIMATELY $315,000 OF THIRD-PARTY RECEIVABLES THAT WERE DETERMINED TO BE TOO-OLD TO BILL AT JUNE 30, 2014, THERE ARE NO ALLOWANCES FOR UNCOLLECTIBLE THIRD-PARTY RECEIVABLES CHARITY CARE THE ORGANIZATION PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES THE ORGANIZATION MAINTAINS RECORDS TO IDENTIFY THE AMOUNT OF CHARGES FOR SERVICES AND SUPPLIES FURNISHED UNDER THE CHARITY CARE POLICY BECAUSE THE ORGANIZATION DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS NET PATIENT SERVICE REVENUE

Form and Line Reference	Explanation
PART III, LINE 8	THE COSTING METHODOLOGY USED IS COST TO CHARGE RATIO OF 0 80 AS DETERMINED BY THE 2013 MEDICARE COST REPORT

Form and Line Reference	Explanation
PART III, LINE 9B	WHEN PATIENTS ARE KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE, UNCOMPENSATED CARE WILL BE AVAILABLE TO THOSE WHO SUCCESSFULLY APPLY UNDER THE HOSPITAL'S CHARITY CARE POLICY IT WILL BE THE APPLICANT'S RESPONSIBILITY TO DEMONSTRATE INABILITY TO PAY

Form and Line Reference	Explanation
PART VI, LINE 2	THE ORGANIZATION OFFERS WELLNESS SCREENINGS ONCE A YEAR AT NO COST TO THE PUBLIC TO ASSESS HEALTH NEEDS INCLUDED ARE BLOOD PRESSURE CHECKS, DIABETES SCREENINGS, PULMONARY AND RESPIRATORY SCREENINGS, AND EDUCATION ON GOOD HEALTH THIS OFTEN RESULTS IN FOLLOW-UP CARE AFTER RESULTS OF SCREENINGS ARE REVIEWED THE ORGANIZATION ALSO OFFERS A COMMUNITY WEIGHT LOSS PROGRAM (GORED) AS WELL AS WELLNESS LUNCHEONS ON RELATED HEALTH TOPICS

Form and Line Reference	Explanation
PART VI, LINE 3	PATIENTS RECEIVE CHARITY CARE INFORMATION THROUGH THE BUSINESS OFFICE THE ORGANIZATION MAILS BROCHURES REGARDING THE PROGRAM IN PAST DUE STATEMENTS THE ORGANIZATION ALSO GIVES THE BROCHURE TO PEOPLE IN THE COMMUNITY KNOWN TO THE ORGANIZATION THAT DO NOT HAVE INSURANCE UPON ARRIVAL FOR A VISIT THE CHARITY CARE INFORMATION IS PART OF THE INTAKE PROCESS

Form and Line Reference	Explanation
PART VI, LINE 4	AS OF THE CENSUS OF 2010, THERE WERE 2,420 PEOPLE AND 1,086 HOUSEHOLDS RESIDING IN THE COUNTY THE POPULATION DENSITY WAS 3 4 PEOPLE PER SQUARE MILE THERE WERE 1,451 HOUSING UNITS THE RACIAL MAKEUP OF THE COUNTY WAS 98 90% WHITE, 0 20% ASIAN, 0 30% BLACK, 0 50% AMERICAN INDIAN AND ALASKA NATIVE PERSONS, AND 0 10% FROM OTHER RACES THERE WERE 1,086 HOUSEHOLDS OUT OF WHICH 23 80% HAD CHILDREN UNDER THE AGE OF 18 LIVING WITH THEM, 55 00% WERE MARRIED COUPLES LIVING TOGETHER, 5 30% HAD A FEMALE HOUSEHOLDER WITH NO HUSBAND PRESENT, AND 36 90% WERE NON-FAMILIES OF THE NON-FAMILY HOUSEHOLDS, 33 70% OF HOUSEHOLDERS LIVED ALONE AND 18 20% OF HOUSEHOLDERS LIVING ALONE, WERE 65 YEARS OF AGE OR OLDER THE AVERAGE HOUSEHOLD SIZE WAS 2 16 AND THE AVERAGE FAMILY SIZE WAS 2 74 IN THE COUNTY THE POPULATION WAS SPREAD OUT WITH 20 40% UNDER THE AGE OF 19, 2 5% FROM 20 TO 24, 17 30% FROM 25 TO 44, 33 40% FROM 45 TO 64, AND 26 40% WHO WERE 65 YEARS OF AGE OR OLDER THE MEDIAN AGE WAS 51 9 YEARS THE MEDIAN INCOME FOR A HOUSEHOLD IN THE COUNTY WAS $43,000, AND THE MEDIAN INCOME FOR A FAMILY WAS $55,724 ABOUT 5 10% OF FAMILIES AND 9 70% OF THE POPULATION WERE BELOW THE POVERTY LINE, INCLUDING 9 80% OF THOSE UNDER AGE 18 AND 20 2% OF THOSE AGE 65 OR OVER

Form and Line Reference	Explanation
PART VI, LINE 5	THE ORGANIZATION OFFERS A VARIETY OF SERVICES TO THE COMMUNITY TO ASSIST IN TAKING AWAY THE BURDEN OF HAVING TO TRAVEL FOR MEDICAL CARE THE ORGANIZATION ALSO ASSISTS IN ACCOMMODATING ANY FINANCIAL CONCERNS THROUGH THE CHARITY CARE PROGRAM BY DOING BOTH, THE ORGANIZATION HOPES TO BETTER THE WELL-BEING OF THE COMMUNITY THE BOARD OF DIRECTORS IS COMPRISED OF PERSONS WHO RESIDE IN THE PRIMARY SERVICE AREA MEDICAL STAFF PRIVILEGES ARE GIVEN TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY THE ORGANIZATION IS AFFILIATED WITH EMERGENCY HEART NETWORK, ST PAUL RAMSEY BURN CENTER, AND LIFE FLIGHT

Additional Data

Software ID:
Software Version:
EIN: 45-0227753
Name: COOPERSTOWN MEDICAL CENTER

990 Schedule H, Supplemental Information

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
COOPERSTOWN MEDICAL CENTER	
COOPERSTOWN MEDICAL CENTER	PART V, SECTION B, LINE 5D THE CHNA CAN BE FOUND AT THE HOSPITALS WEBSITE HTTP //WWW COO PERMC COM/COMMUNITY_HEALTH_NEEDS_ASSESSMENT_2012 PDF
COOPERSTOWN MEDICAL CENTER	PART V, SECTION B, LINE 6I THE ORGANIZATION OFFERED WELLNESS SCREENINGS AT NO COST TO THE PUBLIC TO ASSESS HEALTH NEEDS THE ORGANIZATION ALSO OFFERED A COMMUNITY WEIGHT LOSS PROG RAM AND WELLNESS LUNCHEONS
COOPERSTOWN MEDICAL CENTER	PART V, SECTION B, LINE 7 THERE ARE SEVERAL NEEDS THAT THE ORGANIZATION IS STILL IN THE P ROCESS OF ADDRESSING FINANCES AND MANAGEMENT TURNOVER HAS BEEN PROHIBITIVE TO THE IMPLEME NTATION PROCESS
COOPERSTOWN MEDICAL CENTER	PART V, SECTION B, LINE 20D 15% MARK UP OFF OF THE BLUE CROSS BLUE SHIELD CHARGE RATES

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 23.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**
▶ **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COOPERSTOWN MEDICAL CENTER

Employer identification number
45-0227753

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Travel for companions ☐ Payments for business use of personal residence ☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e g , maid, chauffeur, chef)			
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III ☐ Compensation committee ☐ Written employment contract ☐ Independent compensation consultant ☑ Compensation survey or study ☐ Form 990 of other organizations ☑ Approval by the board or compensation committee			
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		No
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," to line 5a or 5b, describe in Part III			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii) Do not list any individuals that are not listed on Form 990, Part VII

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1)MOHAN KARKI PHYSICIAN	(i) (ii)	219,065 0	0 0	0 0	2,808 0	4,438 0	226,311 0	0 0
(2)BRIAN TWETE NURSE PRACTITIONER	(i) (ii)	156,896 0	0 0	0 0	3,193 0	6,320 0	166,409 0	0 0
(3)TRENT BITZ NURSE PRACTITIONER	(i) (ii)	179,242 0	0 0	0 0	0 0	2,622 0	181,864 0	0 0

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II
Also complete this part for any additional information

Return Reference	Explanation

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COOPERSTOWN MEDICAL CENTER

Employer identification number
45-0227753

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	CITY OF COOPERSTOWN NORTH DAKOTA	45-6002048		01-09-2014	2,080,000	REFUND A PRIOR ISSUE		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	29,022			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	2,080,000			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	1,314,669			
7	Issuance costs from proceeds				
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds				
11	Other spent proceeds	765,331			
12	Other unspent proceeds				
13	Year of substantial completion	1997			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X							
15	Were the bonds issued as part of an advance refunding issue?		X						
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X						

Part III Private Business Use *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X						
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6	Total of lines 4 and 5								
7	Does the bond issue meet the private security or payment test?		X						
8a	Has there been a sale or disposition of any of the bond financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?		X						

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T?		X						
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X							
b	Exception to rebate?		X						
c	No rebate due?		X						
	If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X							
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X						
7	Has the organization established written procedures to monitor the requirements of section 148?		X						

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?		X						

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

Return Reference	Explanation
SCHEDULE K, PART IV, LINE 2B	THE REBATE CALCULATION IS NOT YET DUE CALCULATIONS ARE DUE ONLY ONCE EVERY 5 YEARS

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COOPERSTOWN MEDICAL CENTER

Employer identification number
45-0227753

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11	
FORM 990, PART VI, SECTION B, LINE 12C	EACH BOARD MEMBER ANNUALLY AND UPON HIRE EACH CORPORATE OFFICER, EXECUTIVE, DEPARTMENT DIR ECTOR, SUPERVISOR OR OTHER INDIVIDUAL, DULY AUTHORIZED BY THE GOVERNING BODY TO CONDUCT BU SINESS ON BEHALF OF COOPERSTOWN MEDICAL CENTER SIGNS A STATEMENT WHICH AFFIRMS THAT SUCH P ERSON 1) HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY, 2) HAS READ AND UNDERSTA NDS THE POLICY, 3) HAS AGREED TO COMPLY WITH THE POLICY, 4) UNDERSTANDS THAT THE ORGANIZAT ION IS AND INCLUDES CHARITABLE ORGANIZATIONS AND THAT IN ORDER TO MAINTAIN ITS FEDERAL TAX EXEMPTION IT MUST ENGAGE PRIMARILY IN ACTIVITIES WHICH FURTHER ONE OR MORE OF ITS TAX-EXE MPT PURPOSES IF A CONFLICT ARISES, THE BOARD WILL ASSIGN A DISINTERESTED PERSON TO INVEST IGATE ALTERNATIVES TO THE PROPSED TRANSACTION OR ARRANGEMENT THE INTERESTED MEMBER IS TO PROVIDE INFORMATION TO THE BOARD, HOWEVER NOT INFLUENCE THE BOARD REGARDING THEIR DECISION
FORM 990, PART VI, SECTION B, LINE 15	THE BOARD OF DIRECTORS DETERMINES AND APPROVES COMPENSATION OF THE CEO KEY EMPLOYEE COMPE NSATION IS DETERMINED USING SURVEYS OF COMPARABLE ORGANIZATIONS COMPENSATION FOR KEY EMPL OYEES IS APPROVED BY THE CEO AND HUMAN RESOURCES DEPARTMENT
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST AND AT THE ANNUAL MEETING
FORM 990, PART IX, LINE 11G	OTHER PROFESSIONAL SERVICES PROGRAM SERVICE EXPENSES 182,099 MANAGEMENT AND GENERAL EXPE NSES 320,157 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 502,256 LAB CONSULTANTS PROGRAM SER VICE EXPENSES 232,300 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EX PENSES 232,300 OUTSIDE PHYSICIAN FEES PROGRAM SERVICE EXPENSES 212,053 MANAGEMENT AND G ENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 212,053 MEDICAL RECORDS - PROF SERVICES PROGRAM SERVICE EXPENSES 106,948 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 106,948
FORM 990, PART XI, LINE 9	OTHER AUDIT ADJUSTMENT TO NET ASSETS -3
FORM 990, PART XII, LINE 2C	THE BOARD OF DIRECTORS ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT AUDITOR THIS PROCESS HAS NOT CHANGED FROM PRIO R YEAR

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COOPERSTOWN MEDICAL CENTER

Employer identification number
45-0227753

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity? Yes	(g) Section 512 (b)(13) controlled entity? No
(1) COOPERSTOWN MEDICAL CENTER FOUNDATION 1200 ROBERTS AVE NE COOPERSTOWN, ND 58425 45-0450301	TO SUPPORT THE PROGRAMS OF THE COOPERSTOWN MEDICAL CENTER	ND	501(C)(3)	LINE 7	COOPERSTOWN MEDICAL CENTER	Yes	

Part III **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

		Yes	No
Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule			
1 During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a		No
b Gift, grant, or capital contribution to related organization(s)	1b		No
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j		No
k Lease of facilities, equipment, or other assets from related organization(s)	1k		No
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		No
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p		No
q Reimbursement paid by related organization(s) for expenses	1q		No
r Other transfer of cash or property to related organization(s)	1r		No
s Other transfer of cash or property from related organization(s)	1s		No

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization See instructions regarding exclusion for certain investment partnerships

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V?UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions)

Return Reference	Explanation

Cooperstown Medical Center and Affiliate

Cooperstown, North Dakota

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2014 and 2013

Cooperstown Medical Center and Affiliate

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2014 and 2013

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WIPFLi LLP

Independent Auditor's Report

Board of Directors
Cooperstown Medical Center
Cooperstown, North Dakota

We have audited the accompanying consolidated financial statements of Cooperstown Medical Center and Affiliate, which comprise the consolidated balance sheets as of June 30, 2014 and 2013, and the related consolidated statements of operations and changes in net deficit and cash flows for the years then ended, and the related notes to the consolidated financial statements.

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, 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.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements 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 entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Cooperstown Medical Center and Affiliate as of June 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States.

Wipfli LLP

November 28, 2014
Minneapolis, Minnesota

Cooperstown Medical Center and Affiliate

Consolidated Balance Sheets

June 30, 2014 and 2013

Assets	2014	2013
Current assets		
Cash	$ 199,479	$ 91,323
Patient accounts receivable - Net	969,256	1,106,887
Other accounts receivable	9,256	10
Pledges receivable	850	850
Inventories	68,074	74,273
Prepaid expenses and other	45,629	52,257
Total current assets	1,292,544	1,325,600
Property and equipment - Net	1,075,613	1,320,449
Other assets		
Unamortized debt issuance costs	18,380	19,932
Tenant security deposits	14,412	14,624
Total other assets	32,792	34,556
TOTAL ASSETS	$ 2,400,949	$ 2,680,605

Liabilities and Net Deficit	2014	2013
Current liabilities		
Current maturities of long-term debt	$ 133,766	$ 153,132
Current portion of capital lease obligations	9,782	8,961
Checks issued in excess of available bank balances	-	56,047
Line of credit	-	397,788
Accounts payable	750,510	870,453
Deferred rent revenue	-	35,209
Accrued liabilities		
Salaries and wages	83,018	47,153
Payroll taxes and other	74,951	52,598
Vacation	92,029	151,640
Health insurance	69,000	69,000
Interest	7,572	5,010
Due to third-party reimbursement programs	187,778	213,162
Total current liabilities	1,408,406	2,060,153
Long-term liabilities		
Long-term debt	2,258,754	1,728,372
Capital lease obligations	17,333	27,105
Tenant security deposits	12,600	12,800
Due to third-party reimbursement programs	132,033	262,838
Total long-term liabilities	2,288,687	2,031,115
Total liabilities	3,829,126	4,091,268
Net deficit	(1,428,177)	(1,410,663)
TOTAL LIABILITIES AND NET DEFICIT	$ 2,400,949	$ 2,680,605

See accompanying notes to consolidated financial statements.

Cooperstown Medical Center and Affiliate

Consolidated Statements of Operations and Changes in Net Deficit

Years Ended June 30, 2014 and 2013

	2014	2013
Revenue		
Patient service revenue, net of contractual adjustments and discounts	$ 3,660,966	$ 4,046,219
Provision for doubtful accounts	(142,732)	(177,703)
Net patient service revenue - Less provision for doubtful accounts	3,518,234	3,868,516
Other operating revenue.		
Rental revenue	429,048	438,068
Assisted living rental and services	198,399	182,372
Grant income	38,102	64,305
Operating and debt service subsidy	351,763	70,138
Other	120,095	123,093
Total revenue	4,655,641	4,746,492
Expenses		
Salaries and wages	1,939,777	2,422,993
Employee benefits	196,503	329,092
Purchased and contracted services	1,162,274	871,723
Supplies and other	1,010,241	983,046
Interest	136,971	120,269
Depreciation and amortization	224,192	249,635
Total expenses	4,669,958	4,976,758
Loss from operations	(14,317)	(230,266)
Other income (loss)		
Interest income	155	3,916
Contributions	28,667	74,117
Impairment loss on property disposals	(32,787)	-
Other	2,160	890
Loss on debt refinancing	(16,846)	-
Special events - Net of expenses	15,454	29,599
Total other income (loss)	(3,197)	108,522
Expenses in excess of revenue	(17,514)	(121,744)

Cooperstown Medical Center and Affiliate

Consolidated Statements of Operations and Changes in Net Deficit (Continued)

Years Ended June 30, 2014 and 2013

	2014	2013
Expenses in excess of revenue - Brought forward	$ (17,514)	$ (121,744)
Net assets released from restrictions	-	44,818
Increase (decrease) in unrestricted net deficit	(17,514)	(76,926)
Temporarily restricted net assets - Amounts released from restrictions	-	(44,818)
Change in net deficit	(17,514)	(121,744)
Net deficit at beginning	(1,410,663)	(1,288,919)
Net deficit at end	$ (1,428,177)	$ (1,410,663)

See accompanying notes to consolidated financial statements.

Cooperstown Medical Center and Affiliate

Consolidated Statements of Cash Flows

Years Ended June 30, 2014 and 2013

	2014	2013
Increase (decrease) in cash and cash equivalents		
Cash flows from operating activities		
Change in net deficit	$ (17,514)	$ (121,744)
Adjustments to reconcile change in net deficit to net cash provided by (used in) operating activities		
Depreciation and amortization	224,192	249,635
Provision for doubtful accounts	142,732	177,703
Impairment loss on property disposals	32,787	-
Loss on debt refinancing	16,846	-
Changes in operating assets and liabilities		
Patient accounts receivable	(5,101)	(464,685)
Other accounts receivable	(9,246)	926
Pledges receivable	-	1,300
Inventories	6,199	(6,584)
Prepaid expenses and other	6,628	8,600
Tenant security deposits	212	(21)
Checks issued in excess of available bank balances	(56,047)	56,047
Accounts payable	(119,940)	(175,219)
Deferred revenue	(35,209)	35,209
Accrued liabilities	1,169	27,009
Due to third-party reimbursement programs	(156,189)	185,000
Tenant security deposits	(200)	(800)
Total adjustments	48,833	94,120
Net cash provided by (used in) operating activities	31,319	(27,624)
Cash flows from investing activities.		
Purchase of property and equipment	(10,833)	-
Proceeds from assets limited as to use	-	105,673
Refund of property and equipment deposit	-	73,999
Net cash provided by (used in) investing activities	(10,833)	179,672

Cooperstown Medical Center and Affiliate

Consolidated Statements of Cash Flows (Continued)

Years Ended June 30, 2014 and 2013

	2014	2013
Cash flows from financing activities		
Principle payments on line of credit - Net	$ (397,788)	$ (4,352)
Proceeds from issuance of bonds	2,080,000	-
Principal payments on long-term debt and short-term notes payable	(1,568,984)	(145,061)
Payment of debt issue costs	(16,597)	-
Payments on capital lease obligation	(8,961)	(8,239)
Net cash provided by (used in) financing activities	87,670	(157,652)
Increase (decrease) in cash and cash equivalents	108,156	(5,604)
Cash at beginning	91,323	96,927
Cash at end	$ 199,479	$ 91,323
Supplemental cash flow information:		
Cash paid during the year for interest	$ 134,409	$ 121,868

See accompanying notes to consolidated financial statements.

Note 1 Summary of Significant Accounting Policies

The Entity

Cooperstown Medical Center (the "Medical Center") is organized as a North Dakota nonprofit organization and consists of an 18-bed critical access hospital (CAH), a 12-unit assisted living facility, and a medical clinic located in Cooperstown, North Dakota. The Medical Center also operates a clinic in Binford, North Dakota and leases a skilled nursing facility in Cooperstown, North Dakota to Griggs County Nursing Home, Inc.

Cooperstown Medical Center Foundation (the "Foundation") is organized as a North Dakota nonprofit corporation for the purposes of assisting the Medical Center in providing health care services to the residents of Griggs County, North Dakota, and the surrounding area. The Medical Center controls the Foundation through control of a majority of the Foundation's Board of Directors.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Medical Center and the Foundation, collectively referred to as the "Organization." All material intercompany accounts and transactions have been eliminated in consolidation.

Financial Statement Presentation

The Organization follows accounting standards contained in the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The ASC is the single source of authoritative accounting principles generally accepted in the United States (GAAP) to be applied to nongovernmental entities in the preparation of financial statements in conformity with GAAP.

Use of Estimates in Preparation of Consolidated Financial Statements

The preparation of the accompanying consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that directly 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 revenue and expenses during the reporting period. Actual results may differ from these estimates.

Note 1 Summary of Significant Accounting Policies (Continued)

Cash and Cash Equivalents

The Organization considers all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents.

Patient Accounts Receivable and Credit Policy

Patient accounts receivable are uncollateralized obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The Organization bills third-party payors on the patients' behalf, or if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary insurance is billed, and patients or residents are billed for copay and deductible amounts that are the patients' responsibility. Payments on accounts receivable are applied to the specific claim identified on the remittance advice or statement.

The Organization's policy is to charge interest at 1% per month on account balances greater than 30 days past due.

Patient accounts receivable are recorded in the accompanying consolidated balance sheets net of contractual adjustments and allowances for doubtful accounts, which reflect management's best estimate of the amounts that will not be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of gross revenue and a credit to patient accounts receivable. In addition, management provides for probable uncollectible amounts, primarily for uninsured patients and amounts patients are personally responsible for, through a reduction of gross revenue and a credit to a valuation allowance.

Note 1 Summary of Significant Accounting Policies (Continued)

Patient Accounts Receivable and Credit Policy (Continued)

In evaluating the collectibility of patient accounts receivable, the Organization analyzes past results and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for doubtful accounts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. Specifically, for receivables associated with services provided to patients who have third-party coverage, the Organization analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for doubtful accounts for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with self-pay patients (which include both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Organization records a significant provision for doubtful accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Inventories

Inventories of supplies are valued at the lower of cost, determined using the first-in, first-out method, or market.

Investments and Investment Income

Investments are measured at fair value in the accompanying consolidated balance sheets. Certificates of deposit are carried at cost plus accrued interest.

Note 1 Summary of Significant Accounting Policies (Continued)

Investments and Investment Income (Continued)

Investment income (including realized gains and losses, interest, and dividends) is reported as other income and is included in expenses in excess of revenue unless the income is restricted by donor or law. Unrealized gains and losses on investments are excluded from the operating indicator unless the investments are trading securities. Realized gains and losses are determined by specific identification.

The Organization monitors the difference between the cost and fair value of its investments. A decline in market value of an individual investment security below cost that is deemed to be other than temporary results in an impairment, and the Organization reduces the investment's carrying value to fair value. A new cost basis is established for the investment, and any impairment loss is recorded as a realized loss on investment income.

Property, Equipment, and Depreciation

Property and equipment acquisitions are recorded at cost or, if donated, at fair value at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included with depreciation expense in the accompanying consolidated financial statements. Estimated useful lives range from 5 to 25 years for land improvements, from 3 to 40 years for buildings and improvements, and from 3 to 25 years for movable equipment.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support and are excluded from expenses in excess of revenue unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Note 1 Summary of Significant Accounting Policies (Continued)

Asset Impairment

The Organization reviews its property and equipment for potential impairment whenever events or changes in circumstance indicate that the carrying value may not be recoverable by comparing the carrying value of the property and equipment with the estimated future net discounted cash flows expected to result from the use of the assets, including cash flows from disposition. Should the sum of the expected future net cash flows be less than the carrying value, the Organization would recognize an impairment loss at that time. An impairment loss of $32,787 was recognized in 2014 for costs related to a building improvement project that was abandoned.

Asset Retirement Obligations

ASC Topic 410, *Accounting for Conditional Asset Retirement Obligations,* clarifies when an entity is required to recognize a liability for a conditional asset retirement obligation. The Organization has considered ASC Topic 410, specifically as it relates to its legal obligation to perform asset retirement activities on the Organization's existing properties. The Organization believes there is an indeterminate settlement date for the asset retirement obligations because the range of time over which the Organization may settle the obligation is unknown and cannot be estimated. As a result, the Organization cannot reasonably estimate the liability related to these asset retirement activities as of June 30, 2014 and 2013.

Unamortized Debt Issuance Costs

Costs related to issuance of long-term debt are amortized over the life of the related debt.

Tenant Security Deposits

Security deposits advanced by tenants of the assisted living units are held in trust by the Organization. A liability is also recorded for amounts advanced by tenants.

Note 1 Summary of Significant Accounting Policies (Continued)

Net Assets

Unrestricted net assets consist of investments and otherwise unrestricted amounts that are available for use in carrying out the mission of the Organization and include those expendable resources which have been designated for special use by the Organization's Board of Directors. Temporarily restricted net assets are those whose use by the Organization has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Organization in perpetuity.

For 2014 and 2013, the Organization has no temporarily or permanently restricted net assets.

Expenses in Excess of Revenue

The accompanying consolidated statements of operations and changes in net deficit include the classification expenses in excess of revenue, which is considered the operating indicator. Changes in unrestricted net deficit, which are excluded from the operating indicator, include unrealized gains and losses on investments other than trading securities and contributions of long-lived assets, including assets acquired using contributions that by donor restriction were to be used for the purposes of acquiring such assets.

Note 1 Summary of Significant Accounting Policies (Continued)

Net Patient Service Revenue

The Organization recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. Certain third-party payor reimbursement agreements are subject to audit and retrospective adjustments. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

For uninsured patients who do not qualify for charity care, the Organization recognized revenue on the basis of its standard rates for services provided. On the basis of historical experience, a significant portion of the Organization's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Organization records a significant provision for doubtful accounts related to uninsured patients in the period services are provided.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The Organization maintains records to identify the amount of charges for services and supplies furnished under the charity care policy. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Rental Revenue

Rental revenue is recognized as it is earned. Advance receipts, if any, are deferred and classified as liabilities until earned.

Assisted Living Rental and Services

Assisted living rental and service income is recognized as it is earned. Advance receipts, if any, are deferred and classified as liabilities until earned.

Note 1 Summary of Significant Accounting Policies (Continued)

Operating Subsidy

Operating subsidy consists of payments received from an area hospital district. The payments are recognized as revenue when received. The hospital district funds the subsidy payments through a levy whose proceeds can be used to support certain operating expenses of the Organization, as allowed under North Dakota Century Code. The Organization received payments of $351,763 and $70,138, in 2014 and 2013, respectively.

Contributions

Contributions are considered available for unrestricted use unless specifically restricted by the donor. Unconditional promises to give cash and other assets to the Organization are reported at fair value at the date the promise is received. Conditional promises to give are not recognized until they become unconditional, that is, when the conditions upon which they depend are substantially met.

Contributions are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net deficit as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

Advertising Costs

Advertising costs are expensed as incurred.

Note 1 Summary of Significant Accounting Policies (Continued)

Income Taxes

The Organization is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (the "Code") and is exempt from federal income taxes on related income pursuant to Section 509(a)(2) of the Code. The Organization is also exempt from state income taxes on related income.

In order to account for any uncertain tax positions, the Organization determines whether it is more likely than not that a tax position will be sustained upon examination of the technical merits of the position, assuming the taxing authority has full knowledge of all information. If the tax position does not meet the more-likely-than-not recognition threshold, the benefit of the tax position is not recognized in the financial statements. The Organization has not recorded any assets or liabilities related to uncertain tax positions or unrecognized tax benefits as of June 30, 2014 or 2013.

The Organization's federal and state returns for tax years 2010 and beyond remain subject to examination by major tax jurisdictions.

Subsequent Events

Subsequent events have been reviewed through November 28, 2014, which is the date the consolidated financial statements were available to be issued.

Note 2 Reimbursement Arrangements With Third-Party Payors

The Organization has agreements with third-party payors that provide for reimbursement at amounts that vary from its established rates. A summary of the basis of reimbursement with major third-party payors follows

Hospital

Medicare - The Organization's hospital is designated as a CAH. Under this designation, inpatient and outpatient hospital services are paid based on a cost-reimbursement methodology. Certain professional services provided by physicians are reimbursed based on prospectively determined fee schedules.

Medicaid - Inpatient and outpatient hospital services are paid based on a cost-reimbursement methodology.

Blue Cross and Others - The Organization has also entered into payment agreements with Blue Cross, certain commercial insurance carriers, and other organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Clinic

Medicare - Clinical services are paid on a fee-screen basis or on a cost-reimbursement basis for rural health clinic services.

Medicaid - Clinical services are paid on prospectively determined rates.

Blue Cross and Others - The Organization has also entered into payment agreements with Blue Cross, certain commercial insurance carriers, and other organizations. The basis for payment to the Organization under these agreements includes payments on a fixed-fee schedule or discounts from established charges.

Note 2 Reimbursement Arrangements With Third-Party Payors (Continued)

Accounting for Contractual Arrangements

The Organization is reimbursed for certain cost-reimbursable items at an interim rate, and final settlements are determined after audit of the Organization's related annual cost reports by the respective Medicare and Medicaid fiscal intermediaries. Estimated provisions to approximate the final expected settlements after review by the intermediaries are included in the accompanying consolidated financial statements. The Organization's cost reports have been examined by the Medicare fiscal intermediary through June 30, 2012, and by Medicaid through June 30, 2011.

Due to Third-Party Reimbursement Programs - Extended Repayment Schedule

In October 2013, the Organization was approved for an extended repayment schedule for $481,000 in overpayments received from the Medicare program during 2013. The extended repayment schedule requires monthly installments of $12,619 including interest at 10.135% through May 28, 2016. At June 30, 2014 and 2013, the outstanding balance due under the extended repayment schedule included in Due to Third-Party Reimbursement Programs in the accompanying consolidated balance sheets was $262,811 and $438,493, respectively. Amounts due in fiscal year 2016 have been reclassified to long-term liabilities in the accompanying consolidated balance sheets.

Laws and Regulation

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, particularly those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Recently, federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenue from patients' services. Management believes the Organization is in substantial compliance with current laws and regulations.

Note 2 Reimbursement Arrangements With Third-Party Payors (Continued)

CMS uses recovery audit contractors (RAC) to search for potentially inaccurate Medicare payments that might have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once the RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. As of June 30, 2014, the Organization has not been notified by RAC of any potential significant reimbursement adjustments.

Note 3 Patient Accounts Receivable

Patient accounts receivable consisted of the following at June 30

	2014	2013
Patient accounts receivable	$ 1,299,256	$ 1,422,230
Less		
Contractual adjustments	190,000	87,243
Allowance for doubtful accounts	140,000	228,100
Patient accounts receivable - Net	$ 969,256	$ 1,106,887

The Organization's allowance for doubtful accounts for self-pay patients decreased from 66% of self-pay patient's accounts receivable at June 30, 2013 to 59% of self-pay patient's accounts receivable at June 30, 2014. The Organization's write-offs of patient accounts receivables, net of recoveries, increased from $46,603 in 2013 to $193,554 in 2014 as the Organization undertook an effort to clean up old receivables. In addition, during 2014 the Organization wrote-off approximately $315,000 of third-party receivables that were determined to be too-old to bill. At June 30, 2014, there are no allowances for uncollectible third-party receivables.

Note 4 Property and Equipment

Property and equipment consisted of the following at June 30:

	2014	2013
Land	$ 133,277	$ 133,277
Land improvements	154,615	154,615
Buildings and improvements	6,035,074	6,035,074
Movable equipment	1,698,396	1,687,562
Total property and equipment	8,021,362	8,010,528
Less - Accumulated depreciation	6,945,749	6,722,866
Net depreciated value	1,075,613	1,287,662
Construction in progress	-	32,787
Property and equipment - Net	$ 1,075,613	$ 1,320,449

Note 5 Line of Credit

At June 30, 2014, the Organization had a line of credit of $200,000 with a bank. The line of credit bears interest at 3.85% at June 30, 2014 and is secured by property and equipment. The line of credit matures January 1, 2015. There were no outstanding borrowings at June 30, 2014.

At June 30, 2013 the Organization had a $400,000 line of credit with an outstanding balance of $397,788. The outstanding balance was refinanced during 2014 as discussed in Note 6.

Note 6 Long-Term Debt

Long-term debt consisted of the following at June 30.

	2014	2013
3.85% Health Care Facilities Refunding Revenue Bonds Series 2014, due in monthly installments of $12,441 including interest through January 2034, secured by a mortgage on the Organization's real estate.	$ 2,050,978	$ -
4.85% Health Care Facilities Revenue Refunding Bonds Series 2010, due in monthly installments of $12,528. The bonds were refinanced in 2014.	-	1,354,360
6.25% note payable, due in monthly installments of $1,689 including interest through January 2016, secured by certain assets.	30,487	48,262
4.50% variable-rate note payable, due in monthly installments of $992. The note was refinanced in 2014.	-	126,130
5.00% note payable, due in monthly installments of $2,652 including interest to December 2021, secured by certain assets.	177,148	199,307
1.00% note payable, due in monthly installments of $1,751 including interest to January 2021, secured by certain assets.	133,907	153,445
Totals	2,392,520	1,881,504
Less - Current maturities	133,766	153,132
Long-term portion	$ 2,258,754	$ 1,728,372

In January 2014, the Organization refinanced the 2010 Health Care Facilities Refunding Revenue Bonds, the 4.5% variable rate note payable, and outstanding balances on short-term notes and lines of credit with the Health Care Facilities Refunding Revenue Bonds, Series 2014.

Note 6 Long-Term Debt (Continued)

The indentures of the Health Care Facilities Refunding Revenue Bonds, Series 2014 provide for various restrictive covenants, including maintenance of various financial ratios. Management believes the Organization is in compliance with such covenants at June 30, 2014.

Scheduled principal payments on long-term debt at June 30, 2014, including current maturities, are summarized as follows.

2015	$ 133,766
2016	130,583
2017	123,447
2018	128,008
2019	132,758
Thereafter	1,743,958
Total	$ 2,392,520

Note 7 Capital Lease Obligations

The Organization uses certain equipment under lease agreements classified as capital leases. Capital lease obligations consisted of the following at June 30

	2014	2013
Capital lease obligation, imputed interest at 8.8%, secured by office equipment, due in monthly installments of $982 through January 2017	$ 27,115	$ 36,066
Less - Current maturities	9,782	8,961
Long-term portion	$ 17,333	$ 27,105

Note 7 Capital Lease Obligations (Continued)

Cost of equipment under capital lease obligations, which is included in movable equipment, was $49,586 at June 30, 2014 and 2013, and accumulated amortization for equipment under capital lease obligations was $26,446 and $16,529 at June 30, 2014 and 2013, respectively.

Minimum future payments under capital lease obligations are as follows

2015	$	11,782
2016		11,782
2017		6,851
Total minimum lease payments		30,415
Amount representing interest		3,300
Present value of net minimum lease payments		27,115
Less - Current portion		9,782
Long-term obligation under capital lease	$	17,333

Note 8 Patient Service Revenue - Net of Contractual Adjustments and Discounts

Patient service revenue, net of contractual adjustments and discounts, consisted of the following at June 30

	2014	2013
Gross patient service revenue		
Inpatient	$ 1,327,161	$ 855,278
Swing bed	480,888	557,508
Outpatient	2,116,618	1,739,176
Rural health clinic	1,130,815	1,196,989
Totals	5,055,482	4,348,951
Less - Contractual adjustments and discounts	1,394,516	302,732
Patient service revenue, net of contractual adjustments and discounts	$ 3,660,966	$ 4,046,219

Medicare was 57% and 53%, and Blue Cross Blue Shield was 18% and 20%, of gross patient service revenue for 2014 and 2013, respectively.

Patient service revenue, net of contractual adjustments and discounts (but before the provision for doubtful accounts), is as follows.

	2014	2013
Third-party payors	$ 3,122,547	$ 3,440,612
Self-pay	538,419	605,607
Patient service revenue, net of contractual adjustments and discounts	$ 3,660,966	$ 4,046,219

Note 9 Charity Care

The Organization maintains records to identify and monitor the level of charity care it provides. The Organization computes the estimated cost of providing charity care by multiplying the ratio of cost to gross charges by the gross uncompensated charges associated with providing charity care. The estimated cost of providing care to patients under the Organization's charity care policy was approximately $53,414 and $657 for 2014 and 2013, respectively.

Note 10 Rental Revenue

Rental revenue consists primarily of rents received under a lease and management agreement (the "Agreement") dated July 1, 2011, with Griggs County Nursing Home (the "Care Center"). The Organization receives rents for building, fixed equipment, and certain movable equipment related to space leased by the Care Center. Rents also include reimbursement for utilities and certain maintenance and administrative costs. The Agreement had an original term through June 30, 2012, and has been extended through June 30, 2015. The Agreement can be terminated under certain terms without penalty or cause. Under terms of the Agreement, the Organization receives rent payments of approximately $422,500 for each year the agreement is in effect.

The Agreement also provides for the Organization to sell certain services and employee benefits to the Care Center. The Organization sells services to the Care Center at its estimated costs and health insurance coverage for Care Center employees at rates established by the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA rates"). The Organization also purchases laundry, dietary, and other services from the Care Center. The Care Center sells these services to the Organization at its estimated cost.

Note 10 Rental Revenue (Continued)

Transactions with the Care Center under the Agreement for the years ended June 30 are reported in the consolidated statements of operations and changes in net deficit as follows

	2014	2013
Income and reductions of expense for facilities and services provided to the Care Center.		
Rental revenue	$ 422,508	$ 422,508
Other operating income	48,490	50,205
Employee benefits	400,372	326,848
Expenses for services purchased from the Care Center		
Purchased and contracted services	128,501	152,874

Accounts payable include $274,974 and $319,826 due to the Care Center at June 30, 2014 and 2013, respectively, related to the items above.

Note 11 Functional Expenses

The Organization provides general health care services to residents within its geographic location. Expenses related to providing these services consisted of the following

	2014	2013
Health care services	$ 4,159,133	$ 4,432,374
General and administrative	510,825	544,384
Total expenses	$ 4,669,958	$ 4,976,758

Note 12 Professional Liability Insurance

The Organization's professional liability insurance for claim losses of less than $1,000,000 per claim and $5,000,000 per year covers professional liability claims reported during a policy year (claims made coverage). The professional liability insurance policy is renewable annually and has been renewed by the insurance carrier for the annual period extending through January 1, 2015.

Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the Organization. Although there exists the possibility of claims arising from services provided to patients through June 30, 2014, which have not yet been asserted, the Organization is unable to determine the ultimate cost, if any, of such possible claims, and accordingly no provision has been made.

Note 13 Retirement Plan

The Organization has a defined contribution retirement plan covering substantially all employees. The Organization made discretionary matching contributions based on the participants' total compensation. The Organization matched the first 2% of compensation contributed in 2014 and 2013. Retirement plan expense totaled $25,285 and $28,999 in 2014 and 2013, respectively.

Note 14 Self-Funded Insurance

The Organization has a self-funded health care plan that provides medical benefits to employees and their dependents. Employees share in the cost of health benefits. Health care expense is based on actual claims paid, reinsurance premiums, administration fees, and unpaid claims at year-end. The Organization buys reinsurance to cover individual claims over $40,000.

Health care expense totaled $25,267 and $124,811 for 2014 and 2013, respectively. A liability of $69,000 for claims outstanding at June 30, 2014 and 2013 has been recorded in accrued liabilities in the accompanying consolidated balance sheets. Management believes this liability is sufficient to cover estimated claims, including claims incurred but not yet reported.

Note 15 Commitments and Contingencies

Under terms of a commercial guaranty agreement dated January 30, 2012, the Organization has guaranteed a $300,000 variable rate note payable (the "Note") for the Care Center. At June 30, 2014, the outstanding balance on the Note was $210,953 with interest at 4.75%. The Note matures February 2019.

Management Agreement

The Board of Directors of the Organization entered into a Management Agreement (the "Contract") with Health Management Services under a contract dated August 28, 2013. Under term of the contract, Health Management Services provides the Organization with a hospital administrator and provides various administrative and oversight services. The term of the contract is through August 15, 2018. Under terms of the Contract, the Organization pays fees of $10,100 per month with the fee adjusted annually for changes in the consumer price index. The Contract can be terminated under certain terms without penalty or cause.

Note 16 Concentration of Credit Risk

Financial instruments that potentially subject the Organization to possible credit risk consist principally of accounts receivable, cash deposits in excess of insured limits, and investments.

Accounts receivable consist of amounts due from patients, their insurers, or governmental agencies (primarily Medicare and Medicaid) for health care provided to the patients. The majority of the Organization's patients are from Cooperstown, North Dakota, and the surrounding area.

The mix of receivables from patients and third-party payors was as follows at June 30

	2014	2013
Medicare	45 %	31 %
Medicaid	12 %	10 %
Commercial insurance	14 %	21 %
Other third-party payors, patients, and residents	29 %	38 %
Totals	100 %	100 %

Note 16 Concentration of Credit Risk (Continued)

The Organization maintains depository relationships with area financial institutions that are Federal Depository Insurance Corporation (FDIC) insured institutions. Depository accounts at these institutions are insured by the FDIC up to $250,000. At June 30, 2014, the Organization did not exceed the insured limits.

Note 17 Economic Conditions

Over a number of years, recurring losses from operations have resulted in the Organization accumulated a consolidated net deficit of $1,428,177 at June 30, 2014. Management's plans and actions that have been taken in regard to improving the financial performance of the Organization are described below.

Plans implemented to improve the Organization's financial performance and financial position include:

- Entered into a management agreement with Health Management Service, LLC to provide administration and management services and increased oversight over budgeting and expenditures (See Note 15).
- Pursuing participation in the 340b pharmaceutical program to provide an additional source of revenue and provide for a reduction of cost for outpatient drugs.
- The Organization refinanced most of its long-term as well as short term debt obligations over a lengthened repayment period at a lower interest rate to reduce cash flow requirements for debt service in the short-term as well as subsequent long-term periods.
- The Organization has evaluated payroll and staffing structures to make staffing reductions to reduce salary and benefit expenditures.
- The Organization is planning to bring contracted billing and collection services in house to reduce purchased services expense and increase oversight of the billings and collections process to improve cash collections for services provided to patients.
- The Organization is pursuing implementation of electronic health records systems to meet federal requirements and prevent certain negative impacts to future reimbursement.

Note 18 Reclassifications

Certain reclassifications have been made to the 2013 consolidated financial statements to conform to the 2014 classifications.

Supplementary Information

WIPFLi LLP

Independent Auditor's Report on Supplementary Information

Board of Directors
Cooperstown Medical Center
Cooperstown, North Dakota

We have audited the consolidated financial statements of Cooperstown Medical Center and Affiliate as of and for the years ended June 30, 2014 and 2013, and our report thereon dated November 28, 2014, which expressed an unmodified opinion on those financial statements, appears on page 1. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplementary information appearing on pages 32 through 37 is presented for purposes of additional analysis and is 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 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 the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Wipfli LLP

Wipfli LLP

November 28, 2014
Minneapolis, Minnesota

Cooperstown Medical Center and Affiliate

Consolidating Balance Sheets

June 30, 2014

Assets	Medical Center	Foundation	Elimination	Consolidated Total
Current assets				
Cash	$ 90,323	$ 109,156	$ -	$ 199,479
Patient accounts receivable - Net	969,256	-	-	969,256
Other accounts receivable	9,256	-	-	9,256
Pledges receivable	-	850	-	850
Inventories	68,074	-	-	68,074
Prepaid expenses and other	45,629	-	-	45,629
Total current assets	1,182,538	110,006	-	1,292,544
Property and equipment - Net	1,026,764	48,849	-	1,075,613
Other assets.				
Unamortized debt issuance costs	18,380	-	-	18,380
Tenant security deposits	14,412	-	-	14,412
Total other assets	32,792	-	-	32,792
TOTAL ASSETS	$ 2,242,094	$ 158,855	$ -	$ 2,400,949

Liabilities and Net Assets (Deficit)	Medical Center	Foundation	Elimination	Consolidated Total
Current liabilities				
Current maturities of long-term debt	$ 133,766	$ -	$ -	$ 133,766
Current portion of capital lease obligations	9,782	-	-	9,782
Accounts payable	750,344	166	-	750,510
Accrued liabilities				
Salaries and wages	83,018	-	-	83,018
Payroll taxes and other	74,951	-	-	74,951
Vacation	92,029	-	-	92,029
Health insurance	69,000	-	-	69,000
Interest	7,572	-	-	7,572
Due to third-party reimbursement programs	187,778	-	-	187,778
Total current liabilities	1,408,240	166	-	1,408,406
Long-term liabilities				
Long-term debt	2,258,754	-	-	2,258,754
Capital lease obligations	17,333	-	-	17,333
Tenant security deposits	12,600	-	-	12,600
Due to third-party reimbursement programs	132,033	-	-	132,033
Total long-term liabilities	2,420,720	-	-	2,420,720
Total liabilities	3,828,960	166	-	3,829,126
Net assets (deficit)	(1,586,866)	158,689	-	(1,428,177)
TOTAL LIABILITIES AND NET ASSETS (DEFICIT)	$ 2,242,094	$ 158,855	$ -	$ 2,400,949

Cooperstown Medical Center and Affiliate

Consolidating Balance Sheets (Continued)

June 30, 2013

Assets	Medical Center	Foundation	Elimination	Consolidated Total
Current assets				
Cash	$ -	$ 91,323	$ -	$ 91,323
Patient and resident accounts receivable - Net	1,106,887	-	-	1,106,887
Other accounts receivable	10	-	-	10
Pledges receivable	-	850	-	850
Inventories	74,273	-	-	74,273
Prepaid expenses and other	52,257	-	-	52,257
Total current assets	1,233,427	92,173	-	1,325,600
Property and equipment - Net	1,269,238	51,211	-	1,320,449
Other assets				
Unamortized debt issuance costs	19,932	-	-	19,932
Resident trust funds and security deposits	14,624	-	-	14,624
Total other assets	34,556	-	-	34,556
TOTAL ASSETS	$ 2,537,221	$ 143,384	$ -	$ 2,680,605

Liabilities and Net Assets (Deficit)	Medical Center	Foundation	Elimination	Consolidated Total
Current liabilities				
Current maturities of long-term debt	$ 153,132	$ -	$ -	$ 153,132
Current portion of capital lease obligations	8,961	-	-	8,961
Checks issued in excess of available bank balances	56,047	-	-	56,047
Line of credit	397,788	-	-	397,788
Accounts payable	870,453	-	-	870,453
Deferred rent revenue	35,209	-	-	35,209
Accrued liabilities				
Salaries and wages	47,153	-	-	47,153
Payroll taxes and other	52,598	-	-	52,598
Vacation	151,640	-	-	151,640
Health insurance	69,000	-	-	69,000
Interest	5,010	-	-	5,010
Due to third-party reimbursement programs	213,162	-	-	213,162
Total current liabilities	2,060,153	-	-	2,060,153
Long-term liabilities.				
Long-term debt	1,728,372	-	-	1,728,372
Capital lease obligations	27,105	-	-	27,105
Tenant security deposits	12,800	-	-	12,800
Due to third-party reimbursement programs	262,838	-	-	262,838
Total long-term liabilities	2,031,115	-	-	2,031,115
Total liabilities	4,091,268	-	-	4,091,268
Net assets (deficit)	(1,554,047)	143,384	-	(1,410,663)
TOTAL LIABILITIES AND NET ASSETS (DEFICIT)	$ 2,537,221	$ 143,384	$ -	$ 2,680,605

Cooperstown Medical Center and Affiliate

Consolidating Statements of Operations and Changes in Net Deficit

Year Ended June 30, 2014

	Medical Center	Foundation	Elimination	Consolidated Total
Revenue				
Patient service revenue, net of contractual adjustments and discounts	$ 3,660,966	$ -	$ -	$ 3,660,966
Provision for doubtful accounts	(142,732)	-	-	(142,732)
Net patient service revenue - Less provision for doubtful accounts	3,518,234	-	-	3,518,234
Rental revenue	424,548	4,500	-	429,048
Assisted living rental and services	198,399	-	-	198,399
Grant income	38,102	-	-	38,102
Operating and debt service subsidy	351,763	-	-	351,763
Other	120,095	-	-	120,095
Total revenue	4,651,141	4,500	-	4,655,641
Expenses				
Salaries and wages	1,939,777	-	-	1,939,777
Employee benefits	196,503	-	-	196,503
Purchased and contracted services	1,160,574	1,700	-	1,162,274
Supplies and other	1,000,871	29,370	(20,000)	1,010,241
Interest	136,971	-	-	136,971
Depreciation and amortization	221,829	2,363	-	224,192
Total expenses	4,656,525	33,433	(20,000)	4,669,958
Income (loss) from operations	(5,384)	(28,933)	20,000	(14,317)
Other income (loss)				
Interest income	41	114	-	155
Contributions	20,000	28,667	(20,000)	28,667
Impairment loss on property disposals	(32,787)	-	-	(32,787)
Other	2,160	-	-	2,160
Loss on debt refinancing	(16,846)	-	-	(16,846)
Special events - Net of expenses	-	15,454	-	15,454
Total other income (loss)	(27,432)	44,235	(20,000)	(3,197)
Revenue in excess of expenses	(32,816)	15,302	-	(17,514)

Cooperstown Medical Center and Affiliate

Consolidating Statements of Operations and Changes in Net Deficit (Continued)

Year Ended June 30, 2014

	Medical Center	Foundation	Elimination	Consolidated Total
Revenue in excess of expenses - Brought forward	$ (32,816)	$ 15,302	$ -	$ (17,514)
Change in net asset (deficit)	(32,816)	15,302	-	(17,514)
Net asset (deficit) at beginning	(1,554,047)	143,384	-	(1,410,663)
Net assets (deficit) at end	$ (1,586,863)	$ 158,686	$ -	$ (1,428,177)

Cooperstown Medical Center and Affiliate

Consolidating Statements of Operations and Changes in Net Deficit (Continued)

Year Ended June 30, 2013

	Medical Center	Foundation	Elimination	Consolidated Total
Revenue				
Patient service revenue, net of contractual adjustments and discounts	$ 4,046,219	$ -	$ -	$ 4,046,219
Provision for doubtful accounts	(177,703)	-	-	(177,703)
Net patient service revenue - Less provision for doubtful accounts	3,868,516	-	-	3,868,516
Rental revenue	431,148	6,920	-	438,068
Assisted living rental and services	182,372	-	-	182,372
Grant income	64,305	-	-	64,305
Operating and debt service subsidy	70,138	-	-	70,138
Other	123,093	-	-	123,093
Total revenue	4,739,572	6,920	-	4,746,492
Expenses				
Salaries and wages	2,422,993	-	-	2,422,993
Employee benefits	329,092	-	-	329,092
Purchased and contracted services	871,723	-	-	871,723
Supplies and other	943,251	207,295	(167,500)	983,046
Interest	120,269	-	-	120,269
Depreciation and amortization	247,274	2,361	-	249,635
Total expenses	4,934,602	209,656	(167,500)	4,976,758
Income (loss) from operations	(195,030)	(202,736)	167,500	(230,266)
Other income				
Interest income	54	3,862	-	3,916
Contributions	186,280	55,337	(167,500)	74,117
Other	890	-	-	890
Special events - Net of expenses	-	29,599	-	29,599
Total other income	187,224	88,798	(167,500)	108,522
Revenue in excess (deficiency) of expenses	(7,806)	(113,938)	-	(121,744)

Cooperstown Medical Center and Affiliate

Consolidating Statements of Operations and Changes in Net Deficit (Continued)

Year Ended June 30, 2013

	Medical Center	Foundation	Elimination	Consolidated Total
Revenue in excess (deficiency) of expenses -				
Brought forward	$ (7,806)	$ (113,938)	$ -	$ (121,744)
Net assets released from restrictions	44,818	-	-	44,818
Change in unrestricted net assets (deficit)	37,012	(113,938)	-	(76,926)
Temporarily restricted net assets -				
Amounts released from restrictions	(44,818)	-	-	(44,818)
Change in net assets (deficit)	(7,806)	(113,938)	-	(121,744)
Net asset (deficit) at beginning	(1,546,241)	257,322	-	(1,288,919)
Net assets (deficit) at end	$ (1,554,047)	$ 143,384	$ -	$ (1,410,663)

Community Health Needs Assessment

Cooperstown Medical Center
Cooperstown, North Dakota

2012

Completed by

The North Dakota Medicare Rural Hospital Flexibility (Flex) Program
Ken Hall, JD • Karin Becker, PhD Candidate

Center for Rural Health
The University of North Dakota
School of Medicine & Health Sciences
501 N Columbia Road, Stop 9037
Grand Forks, ND 58202-9037

Funded by the Department of Health and Human Services, Health Resources and Services Administration, and the Federal Office of Rural Health Policy

Table of Contents

Introduction

To help inform future decisions and strategic planning, Cooperstown Medical Center (CMC) in Cooperstown, N.D., conducted a community health needs assessment. Through a joint effort, CMC and the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences analyzed community health-related data and solicited input from community members and health care professionals. The Center for Rural Health's involvement was funded through its Medicare Rural Hospital Flexibility (Flex) Program. The Flex Program is federally funded by the Office of Rural Health Policy and as such associated costs of the assessment were covered by a federal grant

To gather feedback from the community, residents of the health care service area and local health care professionals were given the chance to participate in a survey. Additional information was collected through a Community Group comprised of community leaders as well as through one-on-one key informant interviews with community leaders.

The purpose of conducting a community health needs assessment is to describe the health of local people, identify use of local health care services, identify and prioritize community needs, and help health care leaders begin to identify action needed to address the future delivery of health care in the defined area. A health needs assessment benefits the community by: 1) collecting timely input from the local community, providers, and staff; 2) providing an analysis of secondary data related to health conditions, behaviors, and outcomes; 3) compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan; 4) engaging community members about the future of health care delivery; and 5) allowing the community hospital to meet federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a community health needs assessment at least every three years.

Cooperstown Medical Center

Cooperstown Medical Center includes an 18-bed critical access hospital, a rural health clinic, and an assisted living complex. Practicing at the rural health clinic are two full-time physicians, one part-time physician, and two family nurse practitioners These providers practice in several major medical areas ranging from pediatrics to gerontology, including gynecology, prenatal, and baby care.

Cooperstown Medical Center employs nearly 50 people and has an estimated total economic impact on the community of $2.86 million.[1] Its assisted living facility, Park Place, features 12 two-bedroom units. Park Place residents may access CMC services through an enclosed walkway. Also attached to the CMC complex is Griggs County Care Center, a 48-bed nursing home. Nursing home cares is available for long-term care stays, convalescent care, and short-term stays.

Cooperstown's first hospital was opened in 1903, and the current hospital building was built in 1951. The hospital was remodeled and expanded in the 1980s and 1990s. Early promoters of the hospital stressed that the hospital served all of the county and not just the town of Cooperstown. The hospital has historically received strong support from the communities that it serves.

In its mission statement, Cooperstown Medical Center states that it "is dedicated to providing high quality healthcare services in a personalized, compassionate, and professional manner." Its vision statement is: "Cooperstown Medical Center is the medical facility of choice for the residents of this area. Patient care and satisfaction is our highest priority. We are responsive, innovative, and effective at meeting and exceeding the expectations of patients and their families."

[1] Financial impacts were estimated using economic multipliers derived from MIG 2007 IMPLAN data.

Services offered locally by Cooperstown Medical Center include:

General Services

- Assisted living
- Clinic
- Community education
- Hospice
- Lifeline
- Meals on Wheels
- Respite care
- Swing bed services
- Visiting specialists – cardiology
- Visiting specialists – podiatry
- Visiting specialists – psychology
- Visiting specialists – urology

Acute Care Services

- Cardiac services/rehab
- Emergency room
- Hospital (acute care)
- Minor surgical procedures

Screening/Therapy Services

- Holter monitor
- Immunizations
- Laboratory services
- Nutrition counseling
- Occupational therapy/speech therapy
- Physical therapy
- Pulmonary function testing

Radiology Services

- Bone-density
- CT scan
- General x-ray
- Mammography
- Ultrasound

Additionally, other services offered locally by other providers include.

- Dental services
- Hearing aid services
- Nursing home care center
- Optometric/vision services
- WIC (Women, Infants, Children) program

Health Care Facilities and Other Resources

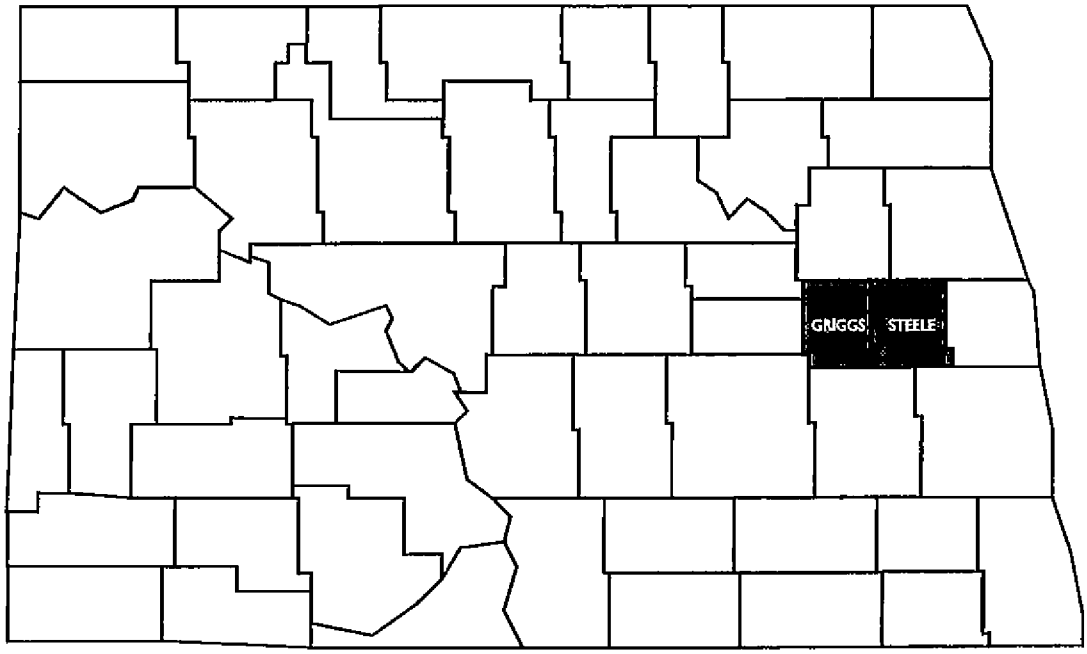
Cooperstown is located in east central North Dakota, within 100 miles of two of North Dakota's larger cities, Fargo and Grand Forks. Both communities have comprehensive medical facilities and state universities. Cooperstown's education system provides basic curriculum and several enrichment programs for its students. The Sheyenne River Valley offers a recreation area for water sports, camping, and hiking. Nearby lakes provide fishing and boating opportunities. A tree-lined nine-hole grass green golf course is located on the northwest edge of town. The Ronald Reagan Minuteman Missile State Historic Site is located just north of Cooperstown

In addition to Cooperstown Medical Center, other health care facilities and services in the area include the attached 48-bed Griggs County Care Center and a retail pharmacy in Cooperstown in addition to the hospital-based pharmacy The area is served by one dentist whose office is in Cooperstown. Four home health agencies (based in Fargo, Grand Forks, and Valley City) offer services in Griggs and Steele counties. The Cooperstown Ambulance Squad is an all-volunteer ambulance service.

Assessment Methodology

Cooperstown Medical Center primarily serves an area in Griggs and Steele counties in eastern North Dakota, although patients from neighboring counties also use the facility. Because the bulk of CMC's patients come from Griggs and Steele counties, this assessment focuses on data from those counties. Included in the hospital's service area are the communities of Binford, Cooperstown, Finley, Hannaford, Hope, Luverne, and Sharon. Figure 1 illustrates the location of Griggs and Steele counties in North Dakota.

Figure 1: Griggs and Steele counties, North Dakota



The Center for Rural Health provided substantial support to CMC in conducting this needs assessment. Center for Rural Health representatives collected data for the assessment in a variety of ways: (1) a survey solicited feedback from area residents; (2) another version of the survey gathered input from health care professionals who work at CMC, (3) community leaders representing the broad interests of the community took part in one-on-one key informant interviews; (4) a Community Group comprised of community leaders and area residents was convened to discuss area health needs; and (5) a wide range of secondary sources of data was examined, providing information on a multitude of measures including demographics; health conditions, indicators, and outcomes; rates of preventive measures; rates of disease; and at-risk activities.

The Center for Rural Health is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The Center serves as a resource to health care providers, health organizations, citizens, researchers, educators, and policymakers across the state of North Dakota and the nation. Activities are targeted toward identifying and researching rural health issues, analyzing health policy, strengthening local capabilities, developing community-based alternatives, and advocating for rural concerns.

As the federally designated State Office of Rural Health (SORH) for the state and the home to the North Dakota Medicare Rural Hospital Flexibility (Flex) program, the Center connects the School of Medicine and Health Sciences and the university to rural communities and their health institutions to facilitate developing and maintaining rural health delivery systems. In this capacity the Center works both at a national level and at state and community levels.

Detailed below are the methods undertaken to gather data for this assessment by convening a Community Group that served as a focus group, conducting key informant interviews, soliciting feedback about health needs via a survey, and researching secondary data.

Community Group

A Community Group consisting of 31 community members was convened and had its first meeting on July 31, 2012. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the CMC service area, and served as a focus group. Focus group topics included the general health needs of the community, general community concerns, community health concerns, delivery of health care by local providers, awareness of health services offered locally, barriers to using local services, suggestions for improving collaboration within the community, reasons community members use CMC, reasons community members use other facilities for health care, and attitudes about the possibility of CMC aligning with a larger health system.

The Community Group met again on October 18, 2012. At this second meeting the Community Group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health and behaviors of the population in the CMC service area. The group was then tasked with identifying and prioritizing the community's health needs

Members of the Community Group represented the broad interests of the community served by CMC. They included representatives of the health community, business community, social service agencies, and elected officials. Members of the Community Group are listed in Appendix B. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with key informants were conducted in person in Cooperstown on July 31, 2012 as well as by telephone. A representative of the Center for Rural Health conducted the interviews. Interviews were held with selected members of the Community Group as well as other key informants who could provide insights into the community's health needs. Included among the informants was a public health nurse with special knowledge in public health acquired through several years of direct care experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases. Those taking part in interviews are listed in Appendix B.

Topics covered during the interviews included the general health needs of the community, local health care delivery concerns, general community concerns, awareness of health services offered locally, barriers to using local services, suggestions for improving collaboration within the community, reasons community members use local health care services, and reasons community members use non-local health facilities, and attitudes about the possibility of CMC aligning with a larger health system.

Survey

A survey was distributed to gather feedback from the community. The survey was not intended to be a scientific or statistically valid sampling of the population. Rather, it was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs.

Two versions of a survey tool were distributed to two different audiences: (1) community members and (2) health care professionals. Copies of both survey instruments are included in Appendix A.

Community Member Survey

The community member survey was distributed to various residents of the service area of Cooperstown Medical Center. The survey tool was designed to:

- Understand community awareness about services provided by the local health system and whether consumers are using local services;
- Understand the community's need for services and concerns about the delivery of health care in the community;
- Learn about broad areas of community concerns;

- Determine preferences for using local health care versus traveling to other facilities;
- Gauge attitudes about the possibility of CMC aligning with a larger health system; and
- Solicit suggestions and help identify any gaps in services

Specifically, the survey covered the following topics: general community concerns, awareness and utilization of local health services, potential community health care delivery concerns, barriers to using local services, levels of collaboration within the community, reasons consumers use CMC and local services, and reasons they seek care elsewhere, travel time to the nearest clinic and to CMC, attitudes about the possibility of CMC aligning with a larger health system, demographics (gender, age, marital status, employment status, income, and insurance status), and respondents' current health conditions or diseases.

Approximately 500 community member surveys were available for distribution in the service area. The surveys were distributed by Community Group members, to patients and guests at CMC's facilities, and at other local public venues To help ensure anonymity, included with each survey was a postage-paid return envelope to the Center for Rural Health. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling CMC. The survey period ran from July 31 to August 31, 2012. Approximately 54 completed surveys were returned.

Area residents also were given the option of completing an online version of the survey, which was publicized in the local newspaper. Seven online surveys were completed In total, counting both paper and online surveys, community members completed 61 surveys.

Health Care Professional Survey

Employees of CMC were encouraged to complete a version of the survey geared to health care professionals. This health care professional version of the survey was administered online only, and 31 surveys were completed The version of the survey for health care professionals covered the same topics as the consumer survey, although it sought less demographic information and did not ask whether health care professionals were aware of the services offered locally.

Secondary Research

Secondary data were collected and analyzed to provide a snapshot of the area's overall health conditions, behaviors, and outcomes. Information was collected from a variety of sources including the U.S. Census Bureau; the North Dakota Department of Health, the Robert Wood Johnson Foundation's County Health Rankings (which pulls data from 14 primary data sources); North Dakota Health Care Review, Inc. (NDHCRI); the National Survey of Children's Health Data Resource Center; North Dakota KIDS COUNT; the Centers for Disease Control and Prevention; the North Dakota Behavioral Risk Factor Surveillance System; and the National Center for Health Statistics.

Demographic Information

Table 1 summarizes general demographic and geographic data about Griggs and Steele counties, which comprise the majority of the service area of Cooperstown Medical Center.

TABLE 1: COUNTY INFORMATION AND DEMOGRAPHICS
(From 2010 Census where available; some figures from earlier Census data)

	Griggs County	Steele County	North Dakota
Population	2,420	1,975	**672,591**
Population change, 2000-2010	-12.1%	-12.5%	**4.7%**
Land area, square miles	709	712	**69,001**
People per square mile	3.4	2.8	**9.7**
White persons	98.9%	97.7%	**90.4%**
Non-English speaking	2.0%	2.7%	**5.4%**
High school graduates	86.0%	88.7%	**89.4%**
Bachelor's degree or higher	19.0%	18.4%	**26.3%**
Live below poverty line	11.4%	4.2%	**12.3%**
Children under 18 in poverty	15%	12%	**16%**
65 years or older	27 2%	21.9%	**14.4%**
Median age	51.9	47.7	**37.0**

The data indicate that both Griggs and Steele counties have a greater percentage of individuals aged 65 or older than the North Dakota average, with more than one in four Griggs County residents aged 65 or older and more than one in five Steele County

residents aged 65 or older. The counties also have considerably higher median ages than the state median age, by more than 10 years in Steele County and nearly 15 years in Griggs County. This likely signifies an increased need for medical care due to an aging population.

Both counties lag behind the state average in terms of individuals with a high school diploma and those with a bachelor's degree or higher. The gap is more pronounced with respect to the percent of college graduates: Griggs County lags the state average by more than seven percentage points while Steele County trails by nearly eight percentage points. The rate of residents who are high school graduates is closer to the state average, with gaps of three percentage points in Griggs County and less than a percentage point in Steele County. The educational backgrounds of area residents can affect a health care facility's ability to find qualified staff members.

Griggs County has a rate of persons living below the poverty line – as well as a rate of children in poverty – that is slightly lower than the state average. Steele County, meanwhile, has a poverty rate that is substantially lower than the state average: The poverty rate of 4.2% is approximately one-third the state average of 12.3%. Steele County's rate of children in poverty (12%) is also lower than the state average (16%), although by not as wide of a margin. Cooperstown Medical Center's service area is rural, with an average of 3.4 people per square mile in Griggs County and 2.8 people per square mile in Steele County, compared to the state average of 9.7 people per square mile. The generally rural area has implications for the delivery of services and residents' access to care. Transportation can be an issue for rural residents as can isolation, which can have many effects on health status.

Health Conditions, Behaviors, and Outcomes

As noted above, several sources were reviewed to inform this assessment. This data is presented below in four categories: (1) County Health Rankings, (2) public health community profiles, (3) preventive care data, and (4) children's health. One other source of information, the Gallup-Healthways Well-Being Index, shows that North Dakota ranked second nationally in well-being during 2011. The index is an average of six sub-indexes, which individually examine life evaluation, emotional health, work environment, physical health, healthy behaviors, and access to basic necessities.

County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, the two counties in CMC's service area are compared to national benchmark data and state rates in various topics ranging from individual health behaviors to the quality of health care.

The data used in the 2012 County Health Rankings is pulled from 16 primary data sources and then is compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors Below is a breakdown of the variables that influence a county's rank. A model of the 2012 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix C. For further information, visit the County Health Rankings website at http://www.countyhealthrankings.org.

Health Outcomes
- Mortality (length of life)
- Morbidity (quality of life)

Health Factors
- Health Behavior
  - Tobacco use
  - Diet and exercise
  - Alcohol use
  - Unsafe sex
- Clinical Care
  - Access to care
  - Quality of care

Health Factors (continued)
- Social and Economic Factors
  - Education
  - Employment
  - Income
  - Family and social support
  - Community safety
- Physical Environment
  - Air quality
  - Built environment

Table 2 summarizes the pertinent information taken from County Health Rankings as it relates to Cooperstown Medical Center's service area in Griggs and Steele counties. It is important to note that these statistics describe the population of each county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily patients of CMC. Moreover, other health facilities are located in other counties that are adjacent to Griggs and Steele counties. For example, other

critical access hospitals are located in adjacent counties in the towns of Carrington, Hillsboro, Jamestown, Mayville, McVille, Northwood, and Valley City. Tertiary hospitals are located in Grand Forks and Fargo, which are approximately 80 and 95 miles from Cooperstown, respectively.

For some of the measures included in the rankings, the County Health Rankings' authors have calculated a national benchmark for 2012. As the authors explain, "The national benchmark is the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (e.g., high school graduation) or negatively (e.g., adult smoking)."

Griggs County's ranking is also listed in Table 2 below. Griggs County ranks 1st out of 46 ranked counties in North Dakota on health outcomes and 2nd on health factors. Due to insufficient data, Steele County was not given numerical rankings on these measures by County Health Rankings. In the table below the variables marked by a red checkmark (✓) are areas where Griggs County is not meeting the state average, while those with a blue checkmark (✓) are areas where Griggs County is not measuring up to the national benchmark. Likewise, the variables marked by a red diamond (◊) are areas where Steele County is not measuring up to state averages, and those with a blue diamond (◊) signify measures on which Steele County is not meeting the national benchmark. Appendix D sets forth definitions for each of the measures.

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS*				
	Griggs County	**Steele County**	**National Benchmark** ✓◊	**North Dakota** ✓◊
Ranking: Outcomes	**1st**	**NR**		**(of 46)**
Poor or fair health	6%	12% ◊	10%	12%
Poor physical health days (in past 30 days)	1.9	2.2	2.6	2.7
Poor mental health days (in past 30 days)	1.1	2.6 ◊◊	2.3	2.5
% Diabetic	9% ✓	9% ◊	-	8%
Ranking: Factors	**2nd**	**NR**		**(of 46)**
Health Behaviors				
Adult smoking	16% ✓	21% ◊✓	14%	19%
Adult obesity	28% ✓	33% ◊✓	25%	30%
Physical inactivity	27% ✓✓	28% ◊✓	21%	26%
Excessive drinking (binge+heavy drinking)	19% ✓	-	8%	22%
Sexually transmitted infections	127 ✓	56	84	305
Clinical Care				
Uninsured residents	13% ✓✓	12% ◊	11%	12%
Primary care provider ratio	585:1	-	631:1	665:1
Mental health provider ratio	2,340:0 ✓	1,805:0 ◊	-	2,555:1
Preventable hospital stays	60 ✓	-	49	64
Diabetic screening	91%	97%	89%	85%
Physical Environment				
Limited access to healthy foods	14% ✓✓	31% ◊◊	0%	11%
Access to recreational facilities	43	0 ◊✓	16	13
Fast food restaurants	25%	0%	25%	41%

✓ = Griggs County not meeting state average ◊ = Steele County not meeting state average
✓ = Griggs County not meeting national benchmark ◊ = Steele County not meeting national benchmark

With respect to health outcomes, Griggs County showed a substantially lower percentage of adults (6%) self-reporting poor or fair health than the state average (12%) and the national benchmark (10%), while Steele County's rate matched the state average and did not meet the national benchmark. Griggs County also was performing considerably better than the North Dakota average and the national benchmark in terms of self-reported number of poor physical health and mental health days each month.

Griggs County residents reported on average 1.9 poor physical health days each month, compared to the state average of 2.7 and the national benchmark of 2.6. For self-reported poor mental health days, Griggs County residents reported on average 1.1 days per month compared, to a state average of 2.5 days and the national benchmark of 2.3 days.

Steele County was besting both the state average and national benchmark in terms of poor physical health days, at 2.2, but fell short of the state average and national benchmark on the measure of poor mental health days, at 2.6.

Nine percent of adults aged 20 and above in both Griggs and Steele counties have diagnosed diabetes, compared to a state average of 8%.

With respect to health factors, including health behaviors, clinical care measures, and physical environment, Griggs County was not measuring up to the state averages in a few categories. Griggs County showed results that were worse than the state average (as well as the national benchmark where a national benchmark has been calculated) on the following measures:

- Physical inactivity
- Uninsured residents
- Mental health provider ratio
- Limited access to healthy foods

Most of the gaps between the Griggs County rate and the North Dakota rate on these measures tended to be fairly small. It is worth noting, however, that because there are no qualifying mental health providers in the county, the ratio of county residents to mental health providers was substantially higher than the state ratio.

Additionally, Griggs County was not meeting the national benchmarks on the following measures:

- Adult smoking
- Adult obesity
- Excessive drinking
- Sexually transmitted infections
- Preventable hospital stays

The rate of excessive drinking (a measure that includes both binge drinking and heavy drinking) in Griggs County was nearly 2½ times the national benchmark. On the positive side, the county was meeting or doing better than the national benchmark (meaning it ranks in the top 10% of counties nationally) in terms of the ratio of residents to primary care providers, diabetic screening, access to recreational facilities, and the prevalence of fast food restaurants.

Steele County performed worse than Griggs County on several measures and was not meeting the state averages on the following measures:

- Adult smoking
- Adult obesity
- Physical inactivity
- Mental health provider ratio
- Limited access to healthy foods
- Limited access to recreational facilities

Notably, the rates in Steele County of adult smoking, adult obesity, and physical inactivity were substantially higher than the national benchmarks, with rates seven, eight, and seven percentage points higher, respectively. Limited access to health foods was more pronounced in Steele County than in Griggs County. On the positive side, Steele County was besting the national benchmark (meaning it was in the top 10% of counties nationwide) on the measures of sexually transmitted infections, diabetic screening, and the prevalence of fast food restaurants.

Public Health Community Health Profile

Included as Appendix E is the North Dakota Department of Health's community health profile for the Nelson-Griggs District Health Unit, which includes Griggs County along with Nelson County, located directly north of Griggs County. Included as Appendix F is the community health profile for Steele County, which is served by the Steele County Public Health Department. Data concerning causes of death are from 2004 to 2008.

In the Nelson-Griggs Health Unit, the leading cause of death for infants, children, and adults up to the age of 44 is unintentional injury. Cancer is the leading cause of death for adults aged 45-84, while heart disease is the leading cause of death for those aged 85 and older. Suicide is the second most common cause of death for those aged 25 to 34, while cancer and heart disease make up the second most common causes of death among the other age groups. Other common causes of death are chronic obstructive pulmonary disease and stroke. A graph illustrating leading causes of death in various age groups in the two-county area may be found in Appendix E.

In Steele County, the leading causes of death are cancer for those aged 5 to 14 and those aged 55 to 84, unintentional injury for those aged 15 to 34, suicide for those aged 35 to 44, and heart disease for those aged 45 to 54 and 85 and older. Among the second most common causes of death are cancer, heart disease, chronic obstructive pulmonary

disease, and stroke A graph illustrating leading causes of death in various age groups in Steele County may be found in Appendix F.

This data on causes of death suggests that in the counties served by CMC, reductions in mortality may be achieved by focusing on early detection and prevention of cancer and heart disease, as well as prevention of accidents and suicides.

In assessing the region's health needs, attention also should be paid to other information provided in the public health profiles about quality of life issues and conditions such as arthritis, asthma, cardiovascular disease, cholesterol, crime, drinking habits, fruit and vegetable consumption, health insurance, health screening, high blood pressure, mental health, obesity, physical activity, smoking, stroke, tooth loss, and vaccination.

Preventive Care Data

North Dakota Health Care Review, Inc., the state's quality improvement organization, reports rates related to preventive care. They are summarized Table 3 for Griggs and Steele counties.[2] For a comparison with other counties in the state, see the respective maps for each variable found in Appendix G.

Those rates highlighted below in red signify that county falls below the state average on that measure.

[2] The rates were measured using Medicare claims data from 2009 to 2010 for colorectal screenings, and using all claims through 2010 for pneumococcal pneumonia vaccinations, A1C screenings, lipid test screenings, and eye exams The influenza vaccination rates are based on Medicare claims data between March 2009 and March 2010 while the potentially inappropriate medication rates and the percent of drug-drug interactions are determined through analysis of Medicare part D data between January and June of 2010.

TABLE 3: SELECTED PREVENTIVE MEASURES			
	Griggs County	Steele County	North Dakota
Colorectal cancer screening rates	55.1%	57.7%	55.5%
Pneumococcal pneumonia vaccination rates	46.3%	55.4%	51.3%
Influenza vaccination rates	46.2%	64.5%	50.4%
Annual hemoglobin A1C screening rates for patients with diabetes	96.4%	92.5%	92.2%
Annual lipid testing screening rates for patients with diabetes	77.3%	74.6%	81.0%
Annual eye examination screening rates for patients with diabetes	78.5%	65.6%	72.5%
PIM (potentially inappropriate medication) rates	7.3%	7.5%	11.1%
DDI (drug-drug interaction) rates	8.0%	9.6%	9.8%

The data indicate that there is room for improvement in both counties on a number of preventive care measures; Griggs County fell below the state average on four of the eight measures, while Steele County was lagging behind the state average on two of the measures.

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality health care, and information on the child's family, neighborhood, and social context. Data is from 2007. More information about the survey may be found at: http://www.childhealthdata.org/learn/NSCH.

Key measures of the statewide data are summarized below. The rates highlighted in red signify that North Dakota is faring worse on that measure than the national average.

TABLE 4: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children aged 0-17 unless noted otherwise)		
Measure	**North Dakota**	**National**
Children currently insured	91.6%	90.9%
Children whose current insurance is *not* adequate to meet child's needs	26.8%	23.5%
Children who had preventive medical visit in past year	78.9%	88.5%
Children who had preventive dental visit in past year	77.2%	78.4%
Children aged 10-17 whose weight status is at or above the 85th percentile for Body Mass Index	25.7%	31.6%
Children aged 6-17 who engage in daily physical activity	27.1%	29.9%
Children who live in households where someone smokes	26.9%	26.2%
Children aged 6-17 who exhibit two or more positive social skills	95.6%	93.6%
Children aged 6-17 who missed 11 or more days of school in the past year	3.9%	5.8%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	17.6%	19.5%
Children aged 2-17 years having one or more emotional, behavioral, or developmental condition	11.4%	11 3%
Children aged 2-17 with problems requiring counseling who received mental health care	72.4%	60 0%

The data on children's health and conditions reveal that while North Dakota is doing better than the national average on several measures, it is not measuring up to the national average in annual preventive medical and dental visits, with respect to health insurance that is adequate to meet children's needs, and in terms of daily physical activity, households with smokers, developmental screening, and rates of emotional, behavioral or developmental conditions. Approximately 20% or more of the state's children are not receiving an annual preventive medical visit or a preventive dental visit. Lack of preventive care now affects these children's future health status. Access to behavioral health is an issue throughout the state, especially in frontier and rural areas. Anecdotal evidence from the Center for Rural Health indicates that children living in rural areas may be going without care due to the lack of mental health providers in those areas.

Table 5 includes selected county-level measures regarding children's health in North Dakota. The data come from North Dakota KIDS COUNT, a national and state-by-state

effort to track the status of children, sponsored by the Annie E. Casey Foundation KIDS COUNT data focus on main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted in red in the table are those on which the county is doing worse than the state average. The data show that both counties are faring substantially worse than the state averages in terms of uninsured children as well as uninsured children below 200% of the federal poverty level. The data also show a considerable lack of child care resources in Steele County.

TABLE 5: COUNTY-LEVEL MEASURES REGARDING CHILDREN'S HEALTH

	Griggs County	Steele County	North Dakota
Uninsured children (% of population)	15.4%	15.9%	8.1%
Uninsured children below 200% of poverty (% of population)	13.1%	12.5%	5.1%
Children enrolled in Healthy Steps (% of population age 0-18)	3.2%	3.5%	2.4%
Licensed child care capacity (% of population age 0-13)	36.9%	12.2%	33.5%
High school dropouts (% of grade 9-12 enrollment	1.6%	0.7%	2.2%
Children directly impacted by domestic violence (% of population)	2.5%	--	2.9%

Survey Results

Survey Demographics

Two versions of the survey were administered: one to community members and one to health care professionals. With respect to demographics, both versions asked participants about their gender, age, and education level. In addition, health care professionals were asked to state their professions and how long they have worked in the community, and community members were asked about marital status, employment status, household income, and travel time to the nearest clinic and to Cooperstown Medical Center. Figures 2 through 14 illustrate these demographic characteristics of health care professionals and community members.

Throughout this report, numbers (N) instead of percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required to answer all survey questions; they were free to skip any questions they wished.

Community Members and Health Care Professionals

In both response groups, as illustrated in Figures 2 and 3, the number of females responding was more than the number of males responding. In the case of community members, female respondents outnumbered male respondents more than four to one. That ratio expanded to nine to one in the case of health care professionals.

Figure 2: Gender – Community Members

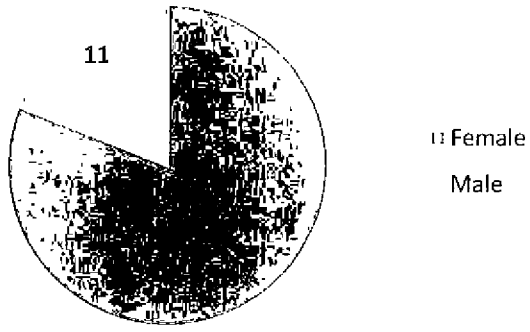
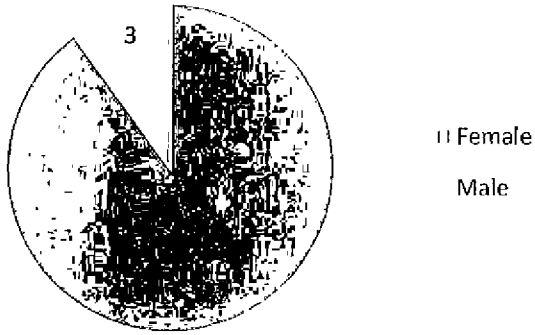


Figure 3: Gender – Health Care Professionals



A plurality of community members completing the survey were between the ages of 55 and 64 (N=19). The next most represented group consisted of those aged 75 and older

(N=13) The two smallest groups of community members responding were those aged 35 to 44 (N=2) and those younger than 25 years (N=0). With respect to health care professionals, the largest age group consisted of those aged 55 to 64 (N=9), while the next two largest age groups were 25 to 34 years old (N=7) and 35 to 44 years old (N=6). Figures 4 and 5 illustrate respondents' ages.

Figure 4: Age – Community Members

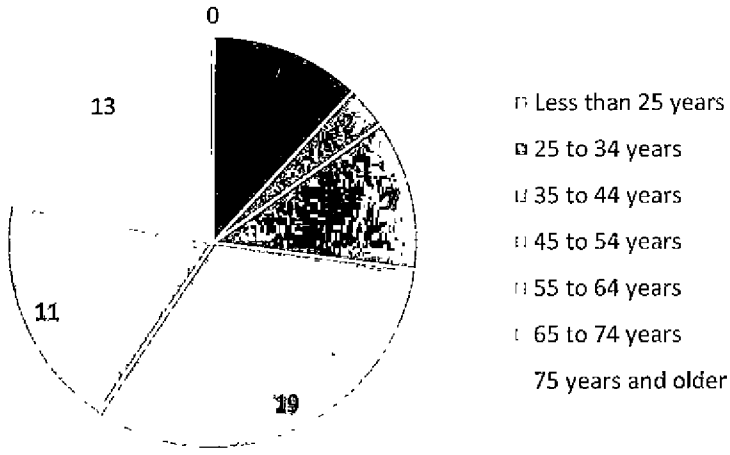
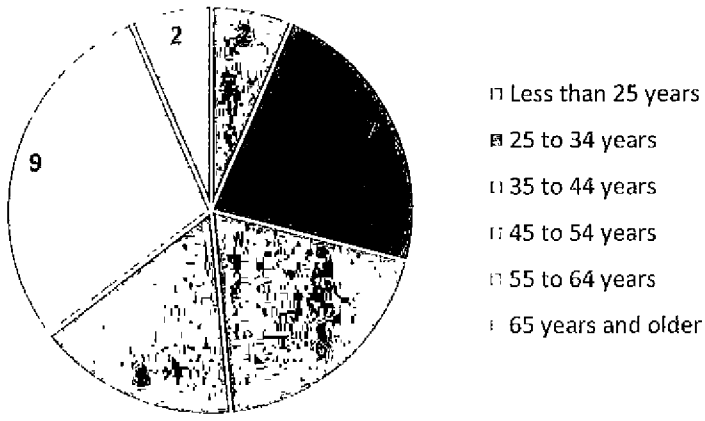


Figure 5: Age – Health Care Professionals



Community members represented a wide range of educational backgrounds, with the largest group having a technical degree or some college (N=19). The next largest groups consisted of those with a bachelor's degree (N=13), and those having a high school diploma or GED (N=12) With respect to health care professionals, a plurality of respondents had a bachelor's degree (N=11). The next most represented groups comprised those with a technical degree or some college (N=7) and those with an associate's degree (N=6). Figures 6 and 7 illustrate the diverse educational background of respondents.

Figure 6: Education Level – Community Members

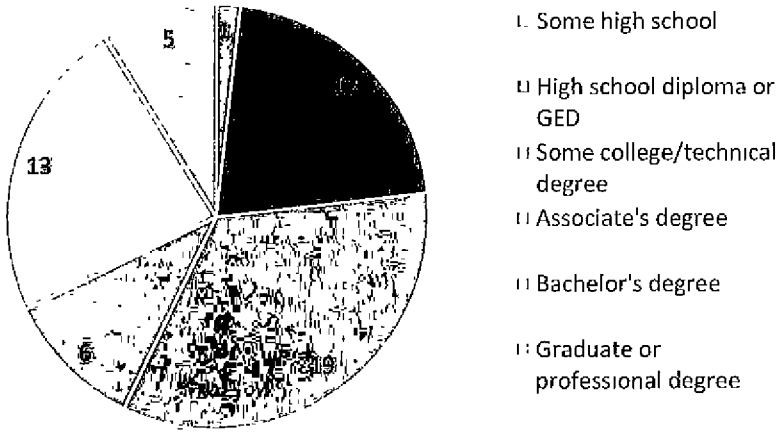
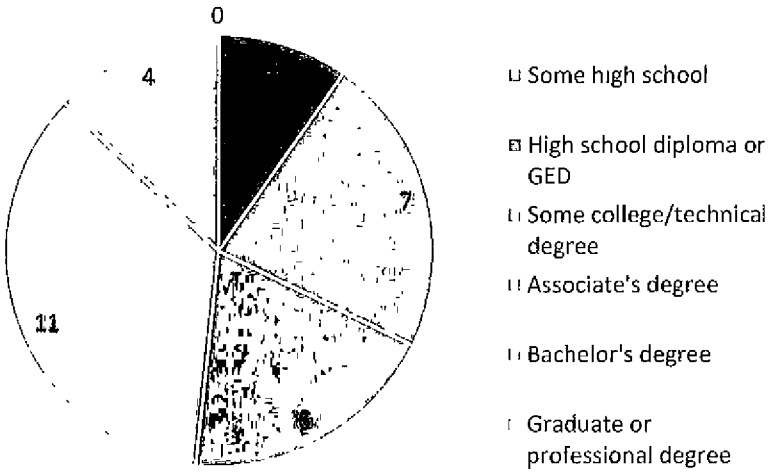


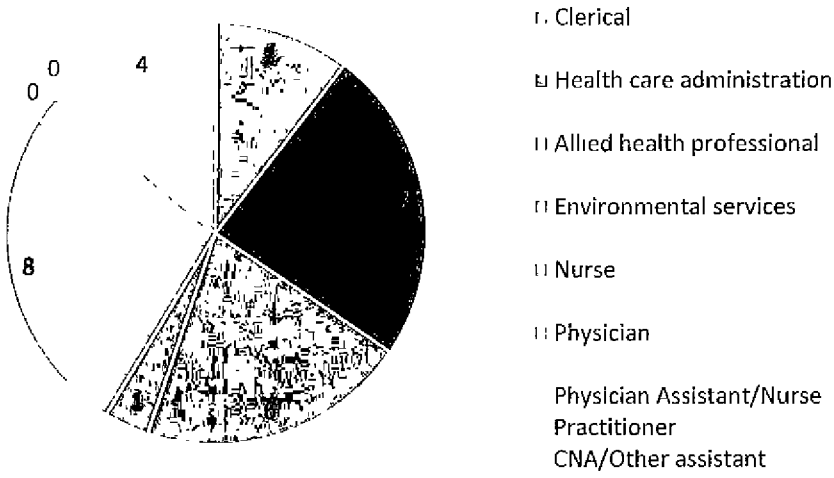
Figure 7: Education Level – Health Care Professionals



Health Care Professionals

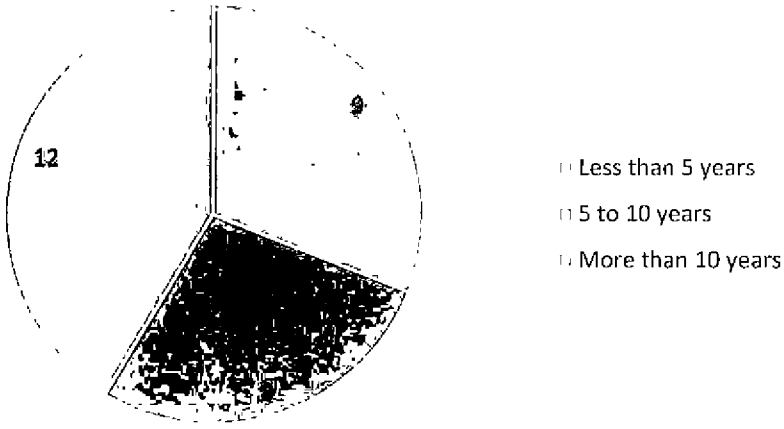
Health care professionals were asked to identify their specific professions within the health care industry. As shown in Figure 8, respondents represented a range of job roles, with the greatest response from nurses (N=8) and those in health care administration (N=7). There were no responses from physicians, physician assistants, or nurse practitioners.

Figure 8: Jobs – Health Care Professionals



Health care professionals also were asked how long they have been employed or in practice in the area. As shown in Figure 9, a plurality of respondents (N=12) indicated they have worked in the area for more than ten years.

Figure 9: Length of Employment or Practice – Health Care Professionals

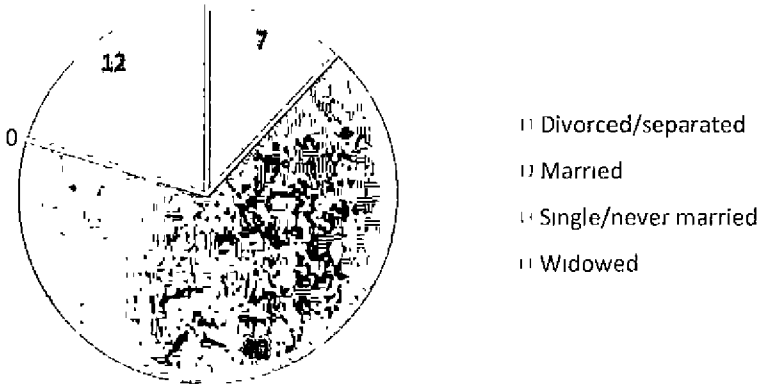


Community Members

Community members were asked additional demographic information not asked of health care professionals. This additional information included marital status, employment status, household income, and their proximity to the nearest clinic and to Cooperstown Medical Center.

A large majority of community members (N=40) identified themselves as married, as exhibited in Figure 10.

Figure 10: Marital Status – Community Members



As illustrated by Figure 11, a plurality of community members reported being employed full time (N=23), followed by retired (N=17).

Figure 11: Employment Status – Community Members

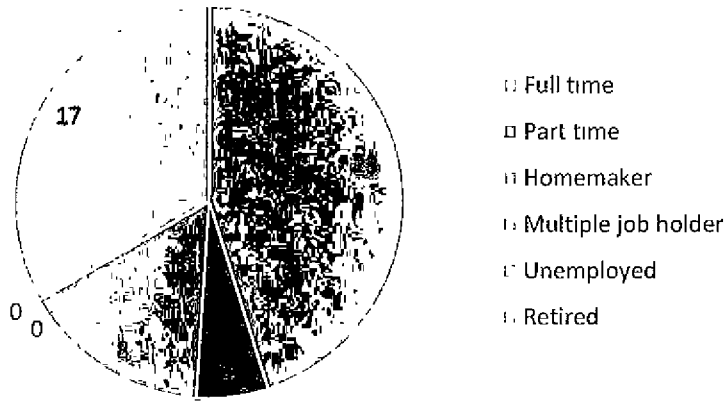
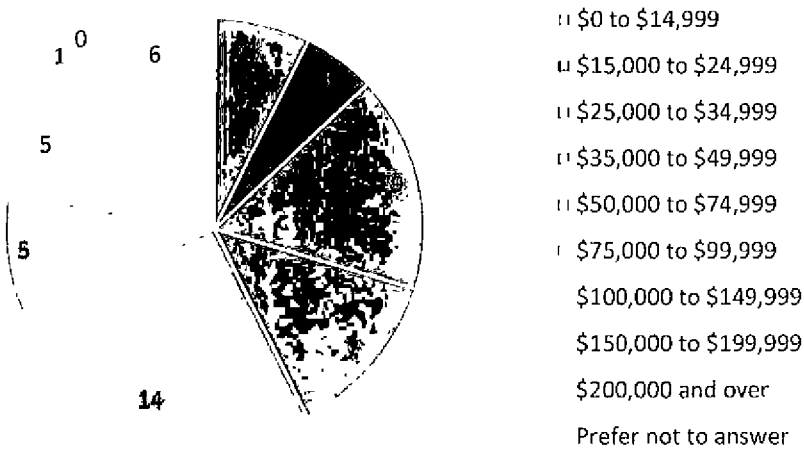


Figure 12 illustrates the wide range of community members' household income and indicates how this assessment took into account input from parties who represent the broad interests of the community served, including lower-income community members. Of those who provided a household income, the most commonly reported annual household income was $50,000-74,999 (N=14), followed by $25,000-34,999 (N=9) and $35,000-49,999 (N=7). Seven community members reported a household income of less than $25,000, while six respondents indicated that they preferred not to answer this question.

Figure 12: Annual Household Income – Community Members



Community members were asked how far they lived from the nearest clinic and how far they lived from Cooperstown Medical Center in Cooperstown. As shown in Figure 13, all respondents answering this question reported living within 30 minutes of Cooperstown Medical Center (N=39 for those living less than 10 minutes away and N=13 for those living 10 to 30 minutes away). With respect to distance to the nearest clinic a plurality of community members responding to the survey lived less than 10 minutes from a clinic (N=24), with the next largest number of respondents (N=11) living 10 to 30 minutes from the nearest clinic, as shown in Figure 14.

Seven respondents indicated that they lived 31 to 60 minutes from the nearest clinic while nine respondents said they lived more than an hour away from a clinic. It is not clear why some respondents indicated living more than 30 minutes from the nearest clinic yet at the same time all those responding to the previous question indicated that they lived within 30 minutes of Cooperstown Medical Center (which includes a rural health clinic). It is possible that some respondents were answering the question about the nearest clinic in terms of the actual clinic they use, and not simply the nearest clinic geographically.

Figure 13: Respondent Travel Time to Cooperstown Medical Center

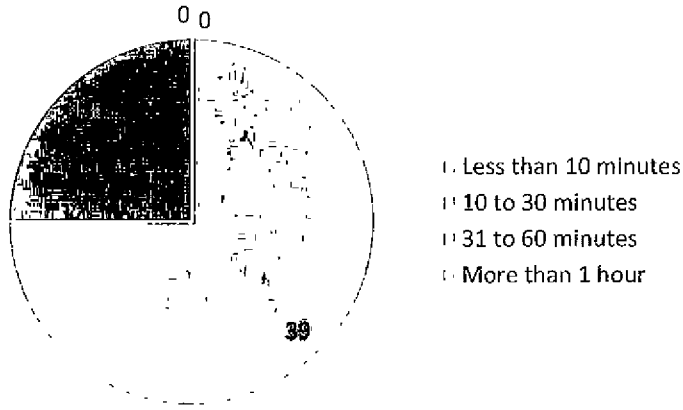
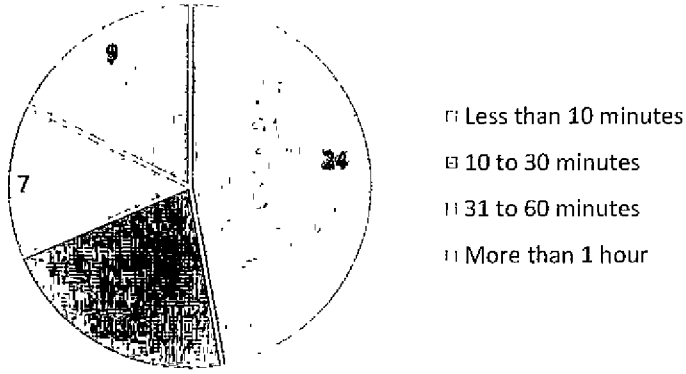


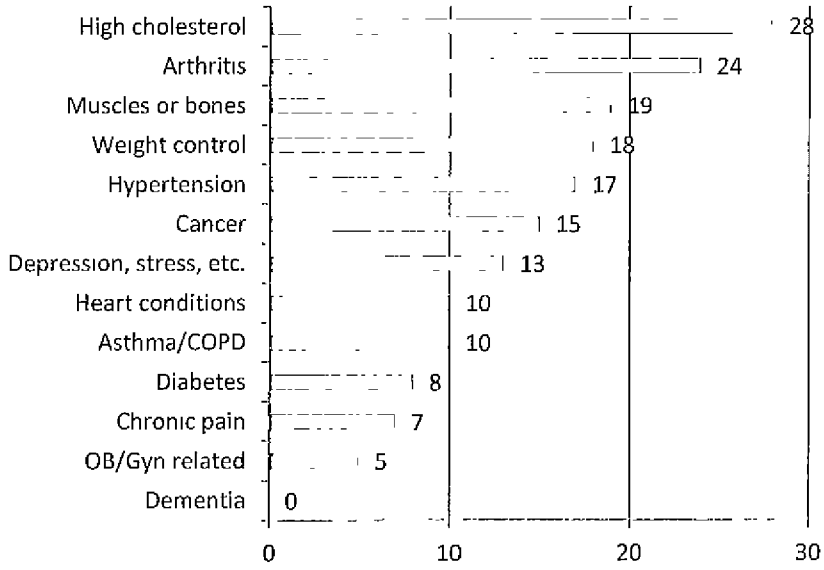
Figure 14: Respondent Travel Time to Nearest Clinic



Health Status and Access

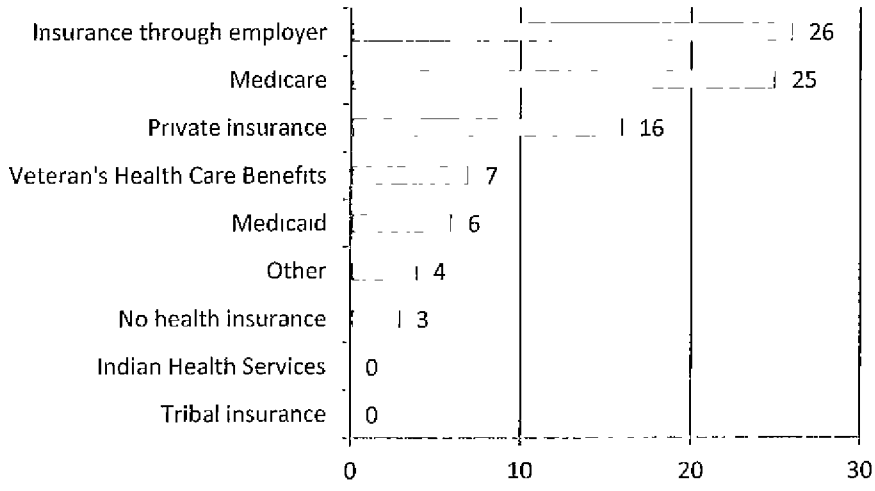
Community members were asked to identify general health conditions and/or diseases that they have. As illustrated in Figure 15, the results demonstrate that the assessment took into account input from those with chronic diseases and conditions. The conditions reported most often were high cholesterol (N=28), arthritis (N=24), muscles or bones (e.g , back problems, broken bones) (N=19), weight control (N=18), and hypertension (N=17).

Figure 15: Health Status - Community Members



Community members also were asked what, if any, health insurance they have Health insurance status often is associated with whether people have access to health care. Three of the respondents reported having no health insurance. As demonstrated in Figure 16, the most common insurance types were insurance through one's employer (N=26), Medicare (N=25), and private insurance (N=16).

Figure 16: Insurance Status – Community Members



General Community Concerns

Respondents were asked to review a list of potential general community concerns and rank each of them on a scale of 1 to 5 based on the importance of each potential concern to the community, with 5 being more of a concern and 1 being less of a concern Community members collectively ranked aging population and the lack of resources to meet growing needs as the top concern (with an average rank of 3.85 on the 5-point scale). Other top concerns of community members were the declining population (3.75), a lack of employment opportunities (3.61), low wages/lack of livable wages (3.58), and maintaining enough health care workers (3.54).

Health care professionals agreed with community members in their assessment of the most important community concern: an aging population and the lack of resources available to meet growing needs. This concern had an average ranking of 3.94 on the 5-point scale. The results of the health care professionals' ranking of community concerns indicated a "tie" for the second most important concern, with an average ranking of 3.84 for both maintaining enough health care workers and low wages/lack of livable wages. Likewise, the next two ranked concerns – lack of employment opportunities and declining population – also were tied, with an average ranking of 3.71. Thus, community members and health care professionals were in agreement in choosing the top five community concerns, including agreement on the most important concern.

The least important concerns among both community members and health care professionals were seen as racism, prejudice, hate, and discrimination, with an average rank of 2.29 among community member and 2 03 among health care professionals.

Concerns that were perceived most differently between community members as opposed to health care professionals were: insufficient facilities for exercise and well-being, which was the 9th highest ranked concern among health care professionals, but the 15th highest ranked concern among community members; and domestic violence, including child abuse, the 10th ranked concern among community members and 14th ranked concern among health care professionals

Figures 17 and 18 illustrate these results.

Figure 17: General Community Concerns of Community Members

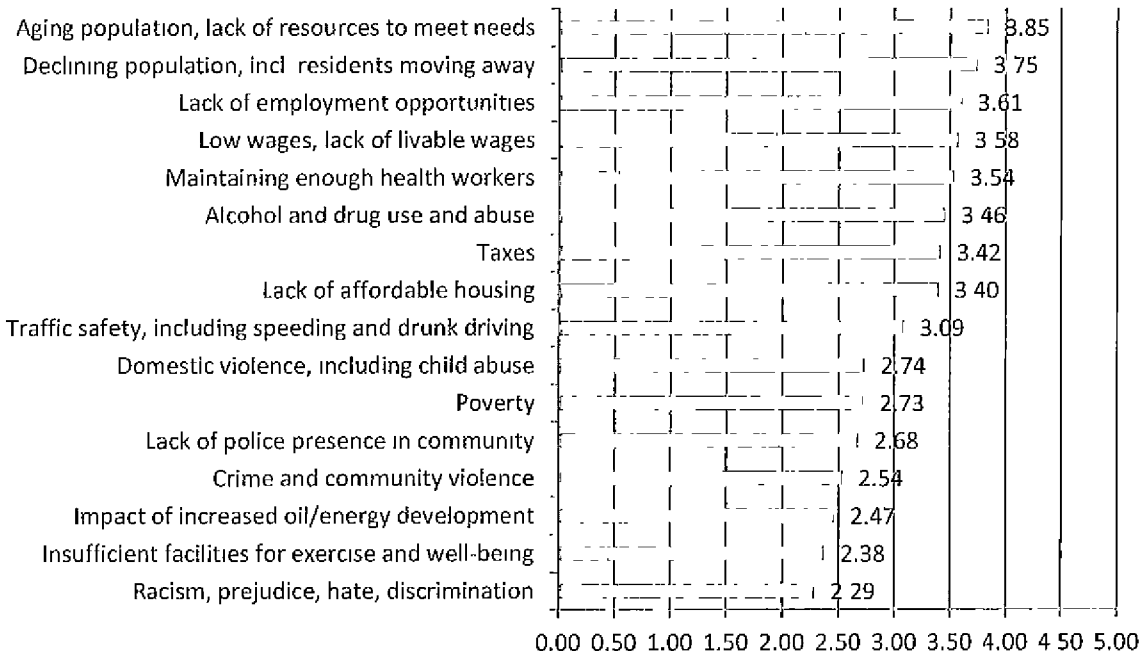
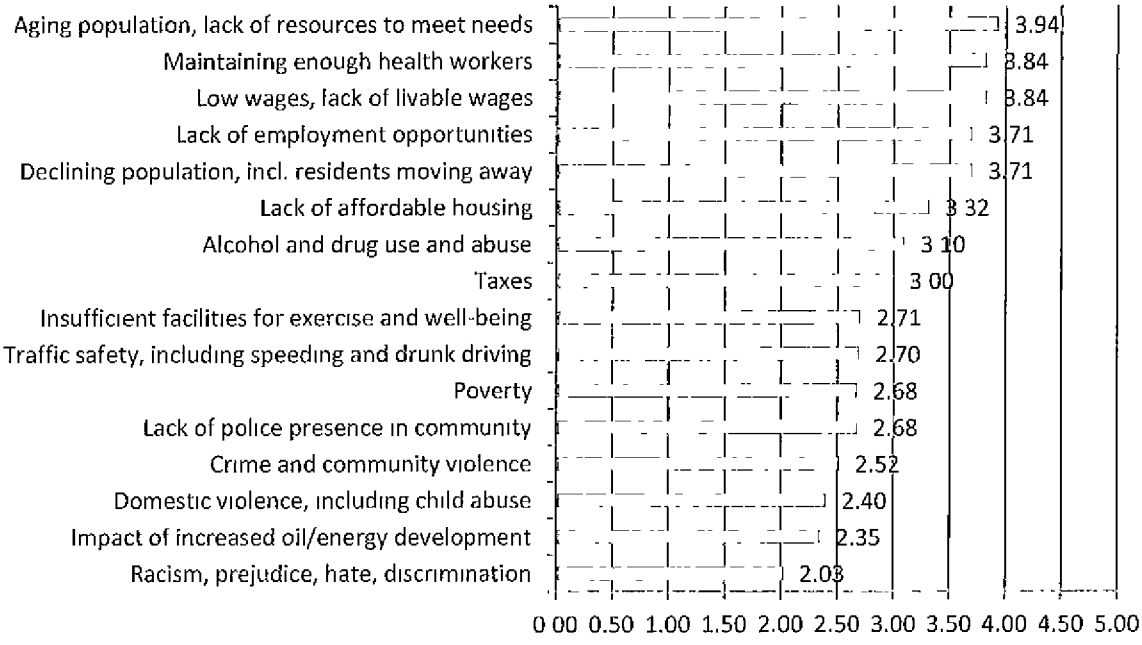


Figure 18: General Community Concerns of Health Care Professionals



In addition to assigning a 1-to-5 ranking to each potential concern, respondents also were asked, in an open-ended question, to identify their most important concern and explain why it was the most important. Forty-five community members answered this question, as did 18 health care professionals.

A plurality of community members (N=14) singled out the declining population, including residents moving away, as the most important concern. Also cited as "most important" concerns were the following:

- Aging population, lack of resources to meet growing needs (N=6)
- Alcohol and drug use and abuse (N=6)
- Lack of affordable housing (N=6)
- Low wages, lack of livable wages (N=6)

Like community members, a plurality of health care professionals (N=6) cited declining population as the most important concern on the list. Health care professionals also pointed to maintaining enough health care workers (N=4) and aging population (N=3) as their "most important" concerns.

Direct comments from both community members and health care professionals about what they collectively viewed as the most important concerns included the following:

Comments relating to the declining population, including residents moving away

- Not enough people to attract business to the town.
- Without people, we lose jobs, services, business, etc
- Residents moving away and fewer children means smaller school, fewer people means fewer workers, empty houses, smaller tax base.
- Declining tax base.
- Without people here we can't afford to keep CMC going and will have to drive even farther away.
- How will running a business survive if the population goes?
- With the loss of population there is loss of patients to keep the doors open to the medical facility. Having fewer residents also puts a strain on taxes, as there are fewer people to pay for the facilities in place.
- We need numbers to support everything in the town.

Comments relating to the aging population and lack of resources to meet growing needs

- People are aging and will need in-home services so they can remain at home We lack a strong home health, hospice, housekeeping services, etc.
- Aging large population of baby boomers will greatly impact health care system.
- Who will take care of the elderly?
- Feel we will lose some of our aging population due to lack of facilities such as apartments and assisted living that are affordable and friendly to the aging population.
- We are seeing people leave their homes but cannot live in what is available so they go to Fargo, where they qualify for cheaper rent and more benefits

Comments related to alcohol and drug use and abuse

- It's increasing rapidly.
- Too many young kids getting hurt
- It's very harmful for users
- Our young people are placing themselves in danger.
- It is at the root of so many problems
- It leads to so many other issues like domestic violence, poverty, injury, etc.

Comments related to low wages and lack of affordable housing

- People have to have 2 or 3 jobs to support family or need Medicaid.
- As prices rise, we are not being compensated adequately on the cost of living raise.
- Without affordable housing, people will move away.
- Because without affordable housing, we cannot bring in more workers or expand in any way.
- If people cannot afford to live here, why would they stay and find a job and support the community?

Community Health Concerns

Similar to the question about general community concerns, respondents were asked to review a list of potential community *health* concerns and rank them on a scale of 1 to 5 based on the importance of each potential concern to the community, with 5 being more of a concern and 1 being less of a concern. Both health care professionals and community members collectively ranked the financial viability of the hospital as the community's

top health concern, with an average ranking of 4.28 among community members and 4.48 among health care professionals. Likewise, the two groups of respondents were in agreement that higher costs of health care for consumers was the community's second most important health concern (4.10 among community members and 4.03 among health care professionals).

Beyond the ranking of the top two concerns, however, there was little alignment among community members and health care professionals in perceiving community health needs. Among community members, rounding out the top five concerns were heart disease (3.71), cancer (3.67), and suicide prevention (3.62). Health care professionals pointed to not enough health care staff in general (3.77), adequate number of providers and specialists (3.77) and mental health (3.71) as the next most common concerns.

Concerns that were perceived most differently between community members as opposed to health care professionals are those that related to workforce issues and particular diseases or chronic conditions. Community members were more likely to place diseases as a higher community concern, while health care professionals tended to see potential shortages of providers and health care staff as important concerns. The issues that were perceived most differently between the two groups of respondents were: not enough health care staff in general, ranked 3rd by health care professionals and 13th by community members; heart disease, slotted 3rd by community members and 10th by health care professionals; diabetes, ranked 6th by community members and 12th by health care professionals; and adequate number of health care providers and specialists, positioned 4th by health care professionals and 10th by community members. These differences in perceptions may reflect that some issues are less noticeable to the general population but more prevalent among health care professionals who see them as part of the delivery of care to the community.

Figures 19 and 20 illustrate these results.

Figure 19: Community Health Concerns of Community Members

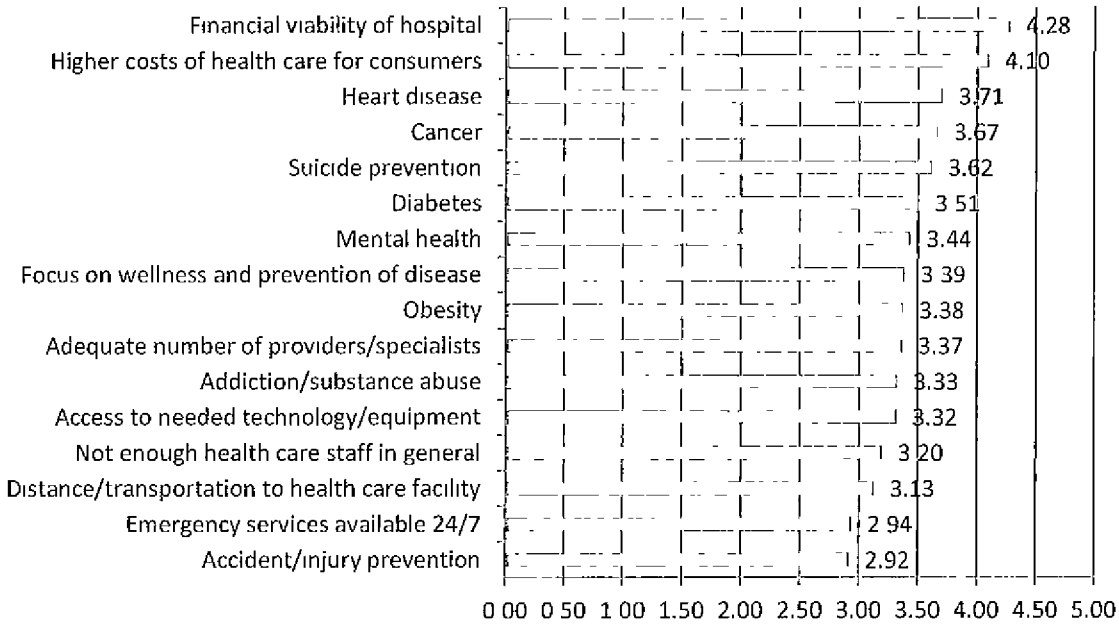
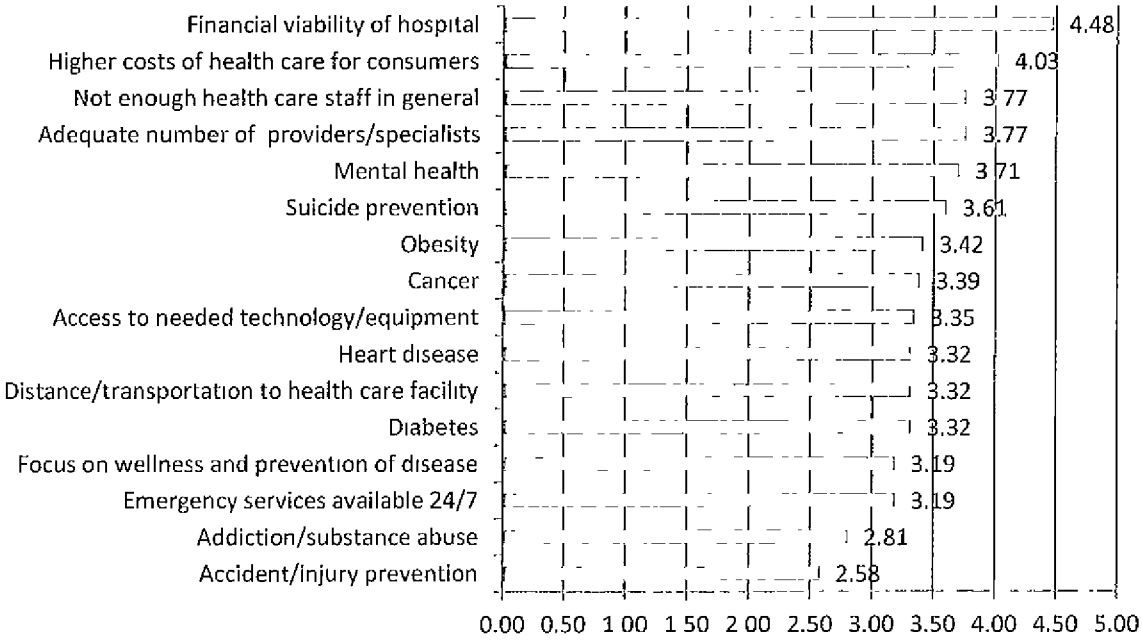


Figure 20: Community Health Concerns of Health Care Professionals



Respondents also were asked, in an open-ended question, to identify their "most important" health concern and explain why it was the most important. Thirty-nine

community members answered this question, as did twelve health care professionals Some respondents chose more than one "most important" concern

A plurality of community members (N=11) singled out the financial viability of the community hospital as the most important concern. Also cited as most important concerns were the following:

- Costs of health care for consumers (N=7)
- Emergency services available 24/7 (N=5)
- Not enough qualified health care staff (N=5)

Among health care professionals, ten respondents cited the financial viability of the hospital, while four pointed to concerns about having enough health care workers. Comments from both community members and health care professionals about what they collectively viewed as the most important health concerns included:

Comments relating to the financial viability of the hospital

- It is difficult to keep a small hospital open. Low census, but costs must still be met.
- The health care facility is of vital importance to our community, for health care and for economics, i.e. employees and dollars turn around.
- More and more regulatory issues.
- If you can't pay the bills, you can't stay open.
- Mega Medical Center moving in
- To insure it remains in community due to rural driving distances to reach health facilities.
- This ties back to the decline in population. No patients, no pay to keep the hospital viable.
- No ability to get ahead Always 6-12 months after service to get paid cost only.
- If the hospital can't make it, then there will be no health care in the community at all.

Comments relating to costs of health care and health insurance

- Higher cost of health care is coming and getting worse
- More people can't afford this high cost of health insurance
- Community does NOT have adequate employment/wages even if health care wasn't SO expensive.

- Money is tight.

Comments related to maintaining enough qualified health care staff

- Not enough heath care staff to take care of the residents more than just doing an adequate job.
- Without enough personnel other goals cannot be accomplished.
- We need people who are good providers and we need good services because we are so far from Grand Forks and Fargo.

Awareness of Services

The survey asked community members whether they were aware of the services offered locally by Cooperstown Medical Center as well as services offered locally by other providers. The health care professional version of the survey did not include this inquiry as it was assumed they were aware of local services due to their direct work in the health care system.

Community members taking the survey generally were aware of many of the services offered by Cooperstown Medical Center and other local providers. In the paper version of the survey, respondents were given the option to check a "Yes" or "No" box for each listed service to indicate whether they were familiar with the service. Because a large number of respondents checked only the "Yes" boxes, reported below are the numbers of "Yes" choices for each service offered. The limitation with this reporting method is that it is implied that the gap between how many answered "Yes" and the total response count reflects those that are not aware. It is unknown, however, whether the difference reflects unawareness or respondents skipping that particular listed service.

The online version included only a choice for "Yes, aware this service is offered at CMC" (or, in the case of services provided locally by other providers, "Yes, aware this service is offered locally"), with respondents able to either select that choice or not. The survey question was asked in subparts, with locally available services divided into five categories: (1) general, (2) acute, (3) screening and therapy, (4) radiology, and (5) services offered by providers other than CMC.

Community members were most aware of the following services (with the parenthetical number indicating the number of survey takers responding that they were aware of the service):

- Immunizations (N=59)

- Clinic (N=58)
- Laboratory services (N=58)
- Assisted living (N=57)
- Physical therapy (N=57)
- Radiology -- general x-ray (N=57)
- Emergency room (N=56)
- Meals on wheels (N=55)
- Swing bed services (N=55)
- Nutrition counseling (N=54)
- Nursing home care center (N=54)

Respondents were least aware of the following services:

- Holter monitor (N=25)
- Pulmonary function testing (N=37)
- Community education (N=40)
- Radiology – bone-density (N=42)
- Radiology – ultrasound (N=43)
- Minor surgical procedures (N=44)
- Radiology – CT scan (N=44)
- Visiting specialists – urology (N=45)
- Hearing aid services (N=45)

These services with lower levels of awareness may present opportunities for further marketing, greater utilization, and increased revenue Figures 21 to 25 illustrate community members' awareness of services.

Figure 21: Community Members' Awareness of Locally Available General Health Care Services

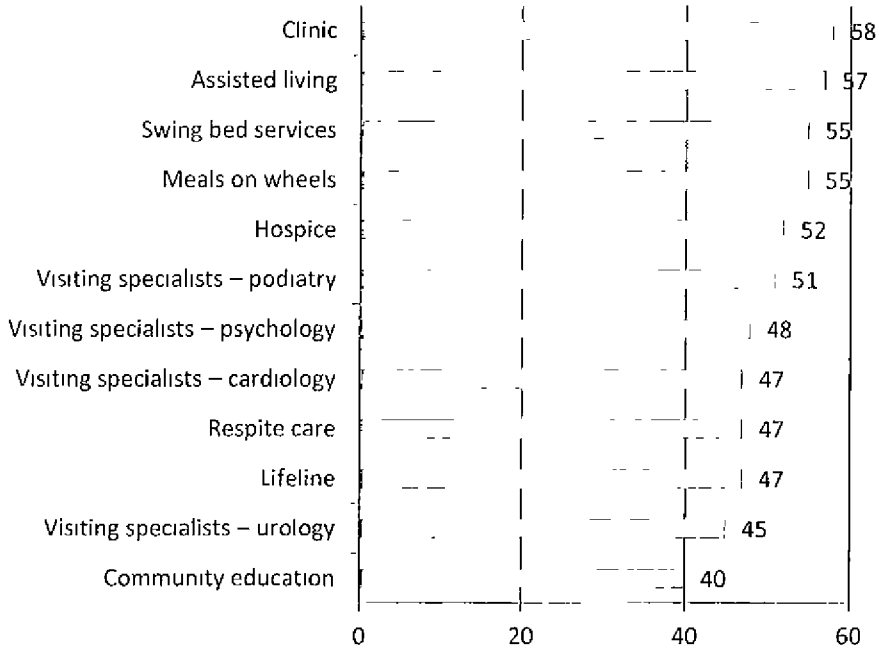


Figure 22: Community Members' Awareness of Locally Available Acute Health Care Services

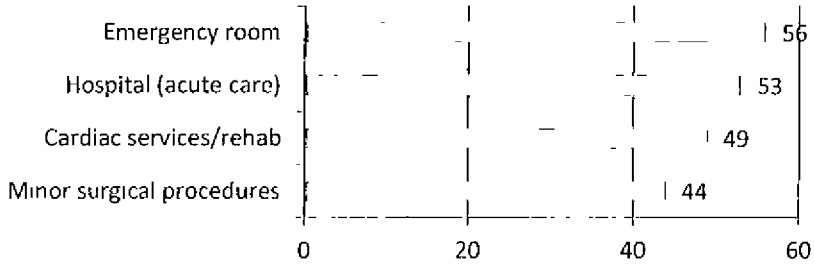


Figure 23: Community Members' Awareness of Locally Available Screening/Therapy Services

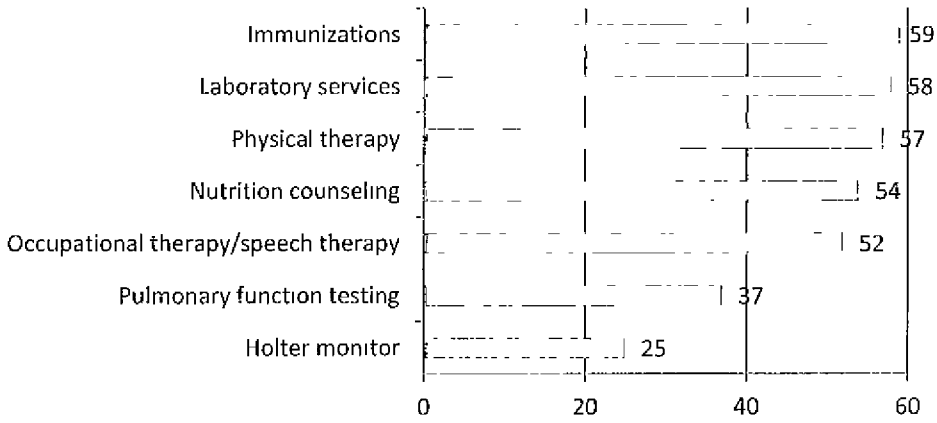


Figure 24: Community Members' Awareness of Locally Available Radiology Services

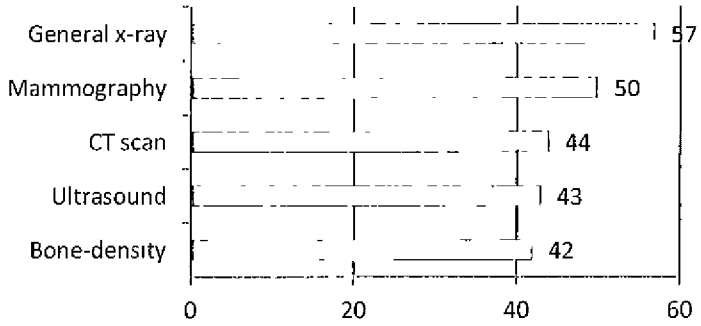
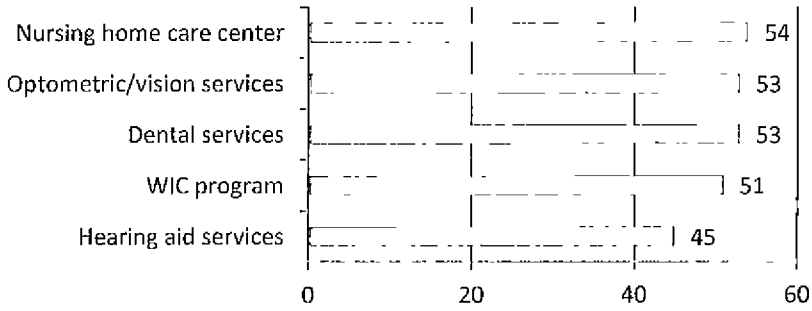


Figure 25: Community Members' Awareness of Services Offered by Providers Other than CMC



Information about how community members learn of local services emerged during the focus group session and key informant interviews Participants said that CMC does a good job in promoting services, but that younger residents in particular may not be as aware of locally offered services. It was suggested that younger residents probably are

not paying attention to the medical center's website because "Facebook is more prevalent now." Multiple participants said that people generally learn about available services through word of mouth. One participant said that there are not many stories in the newspaper that would indicate what services are available, noting that "even people who work at the hospital don't always know what's available as far as social services." Another participant noted that there are advertisements in the newspaper that list when specialists will be in town so people know about those services. As summed up by one interviewee, "When you need services, then you find out about them."

Health Service Use

Community members were asked to review a list of services provided locally by Cooperstown Medical Center, as well as by other local providers, and indicate whether they had used those services locally, out of the area, or both. Figures 26 to 30 illustrate these results.

Community members responding indicated that the services most commonly used locally were:

- Clinic (N=48)
- Laboratory services (N=44)
- Radiology – general x-ray (N=40)
- Emergency room (N=39)
- Optometric/vision services (N=34)
- Immunizations (N=32)
- Physical therapy (N=27)
- Radiology – mammography (N=25)
- Dental services (N=24)

Respondents indicated that the services they most commonly sought out of the area were:

- Dental services (N=32)
- Optometric/vision services (N=26)
- Clinic (N=19)
- Radiology – ultrasound (N=19)
- Laboratory services (N=18)
- Immunizations (N=16)
- Radiology – mammography (N=16)
- Hospital (acute care) (N=15)

- Radiology – general x-ray (N=12)
- Emergency room (N=12)
- Minor surgical procedures (N=12)

As with low-awareness services, these services – for which community members are going elsewhere – may provide opportunities for additional education about their availability from the local health system and potential greater utilization of local services.

Figure 26: Community Member Use of Locally Available General Health Care Services

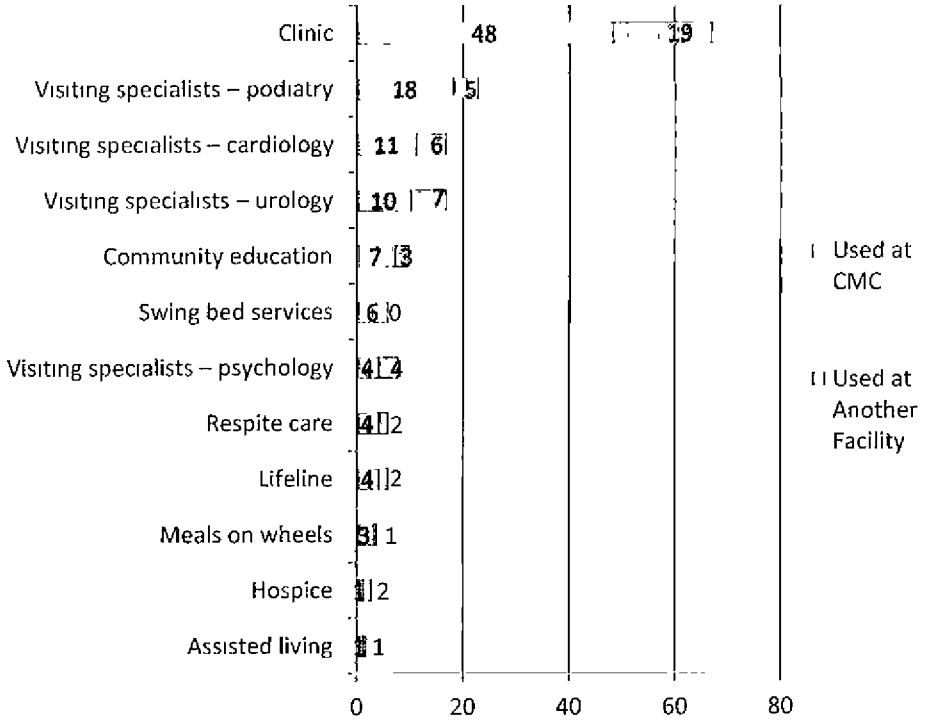


Figure 27: Community Member Use of Locally Available Acute Health Care Services

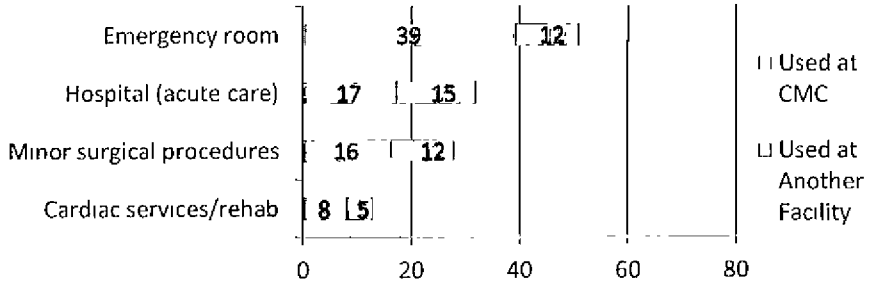


Figure 28: Community Member Use of Locally Available Screening/Therapy Services

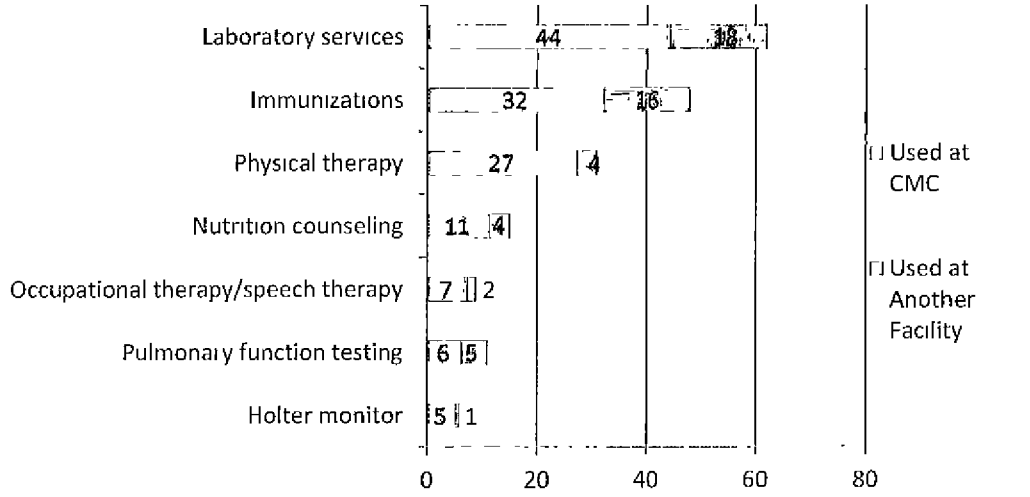


Figure 29: Community Member Use of Locally Available Radiology Services

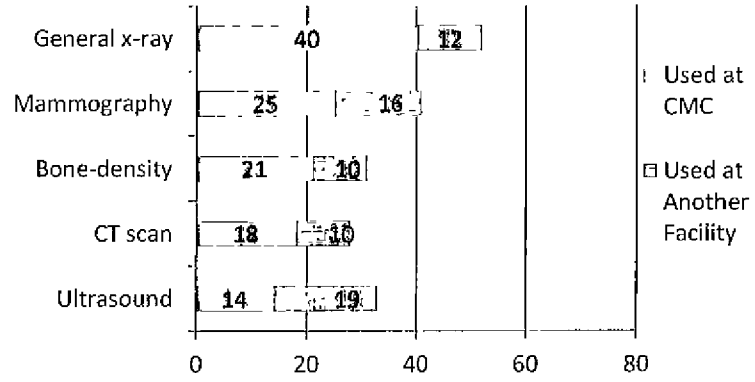
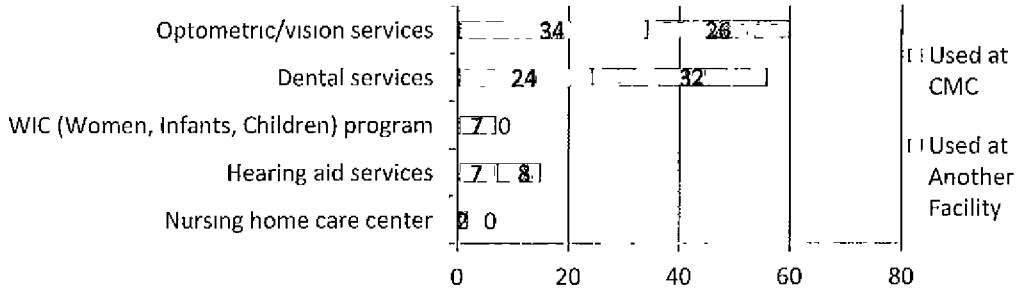


Figure 30: Community Member Use of Services Offered by Providers Other than CMC



Additional Services

In another open-ended question, both community members and health care professionals were asked to identify services they think Cooperstown Medical Center needs to add. Twenty community members provided responses to this question, as did

ten health care professionals. There was a wide range of requested services, with community members supplying two requests each for of the following services:

- Cancer services/chemotherapy
- CT scanner
- Dental services
- Home health/home care services
- Pediatric services

Among health care professionals, the most common suggestion was for a CT scanner, with four respondents requesting it. Among all respondents, a common theme was a desire for increased access to specialists, with one respondent each requesting, a dermatologist, a rheumatologist, and an ear, nose and throat specialist

Reasons for Using Local Health Care Services and Non-Local Health Care Services

The survey asked community members why they seek health care services at Cooperstown Medical Center and why they seek services at other health care facilities. Health care professionals were asked why they think patients use services at CMC and why they think patients use services at other facilities. Respondents were allowed to choose multiple reasons.

Community members most often chose convenience (N=48) and familiarity with providers (N=40) as the reasons for seeking care at CMC Other reasons commonly cited by community members for seeking care at CMC were proximity (N=38) and loyalty to local service providers (N=34). Health care professionals' responses were consistent with those of community members, with health care professionals choosing the same top four choices: convenience (N=28), familiarity with providers (N=27), proximity (N=26), and loyalty to local providers (N=21). Figures 31 and 32 illustrate these responses.

Figure 31: Reasons Community Members Seek Services at Cooperstown Medical Center

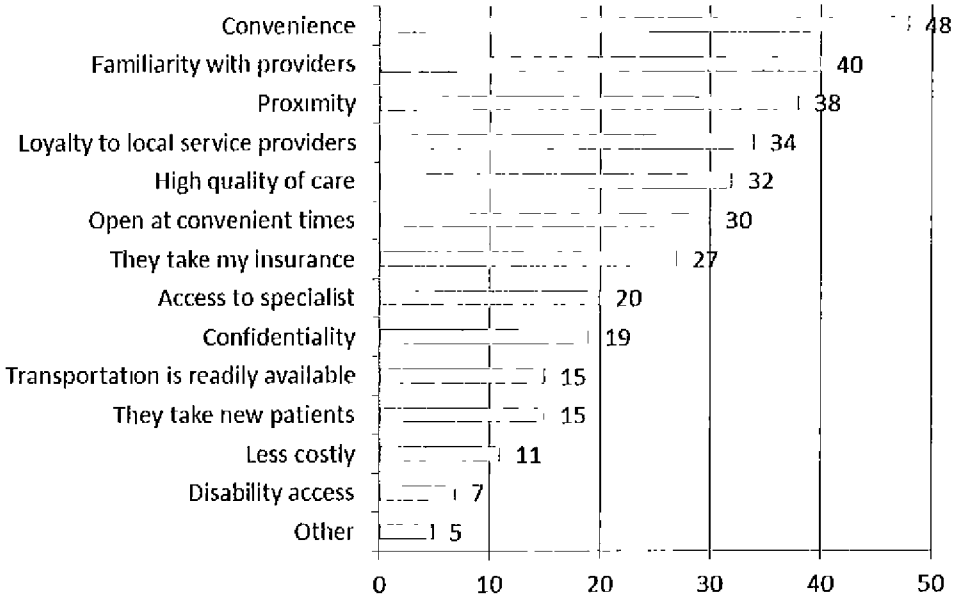
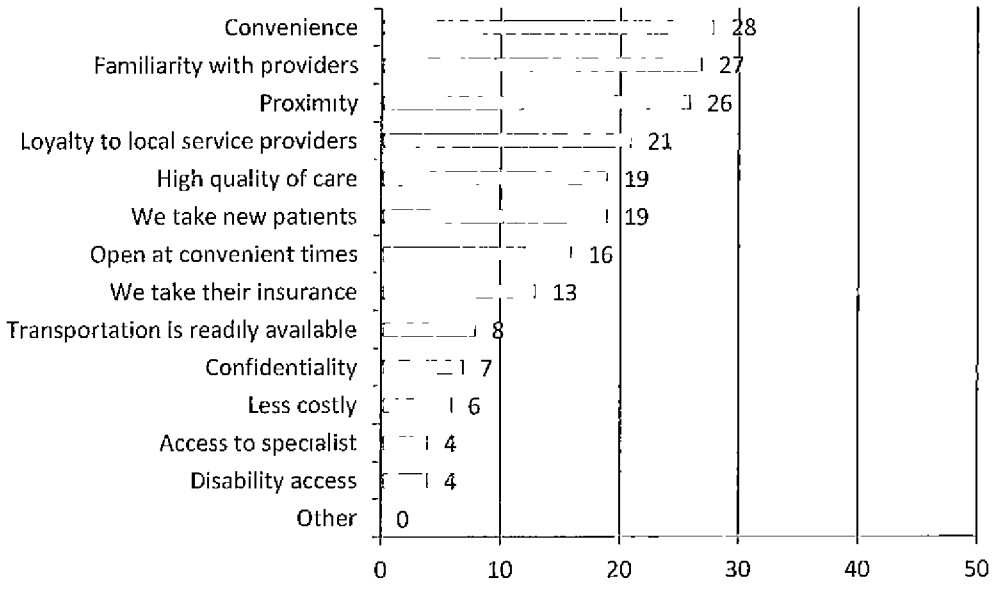


Figure 32: Reasons Health Care Professionals Believe Community Members Seek Services at Cooperstown Medical Center



With respect to the reasons community members seek health care services at other facilities, community members and health care professionals were in agreement that the primary motivator for seeking care elsewhere was, by a considerable margin, that

another facility provides a needed specialist (N=32 for community members; N=29 for health care professionals). Other oft-cited reasons given by community members for seeking care elsewhere were "other" and high quality of care (N=18 for both). Among the more common "other" reasons cited by community members were: a referral was made to a provider elsewhere or specialized care was need (N=7), a desire for pediatric services (N=2), concerns about billing issues (N=2), a preference for continuity of care with a provider with whom a patient has an existing relationship (N=2).

Health care professionals chose confidentiality (N=14) and high quality of care (N=11) as the next top reasons they believe community members seek health care services at other facilities. These results are illustrated in Figures 33 and 34.

Figure 33: Reasons Community Members Seek Services at Other Health Care Facilities

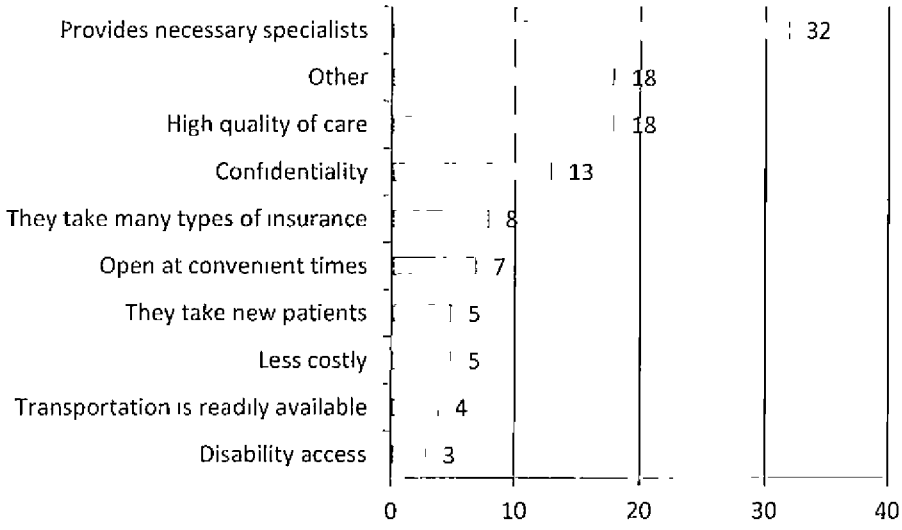
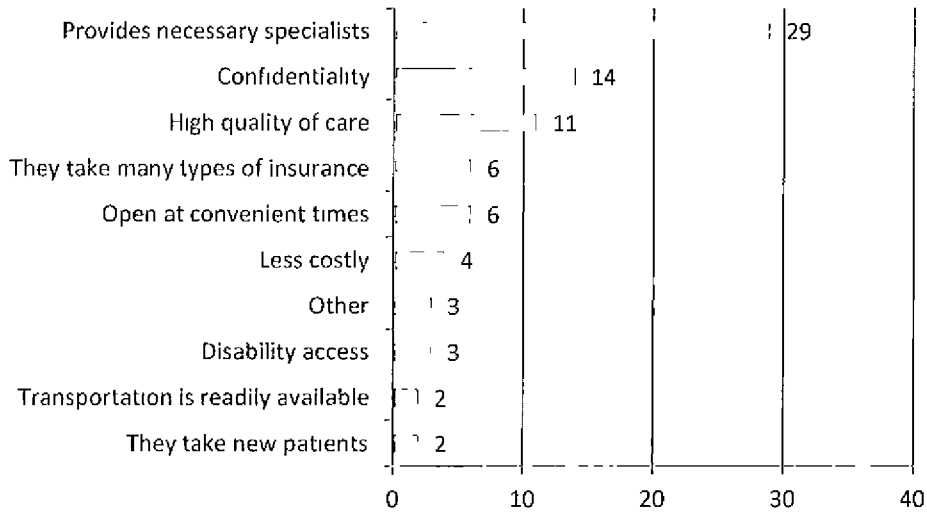


Figure 34: Reasons Health Care Professionals Believe Community Members Seek Services at Other Health Care Facilities



Barriers to Accessing Health Care

Both community members and health care professionals were asked what would help to address the reasons why patients do not seek health care services in the Cooperstown area. Community members and health care professionals agreed in their top recommendations that having greater access to specialists (N=18 for both community members and health care professionals) would help remove barriers to using local care. The next most common responses from community members were "other" (N=14), confidentiality (N=11), and having more doctors (N=8). Health care professionals pointed to having more doctors (N=13), confidentiality (N=7), and greater access to telehealth (N=6).

Among the 14 "other" suggestions from community members for removing barriers to care, six noted that they seek care elsewhere because it was necessary to see a specialist, two said they had existing relationships with other providers, and two pointed to billing issues.

See Figures 35 and 36 for additional items that may help remove barriers to local health care use.

Figure 35: Community Members' Recommendations to Help Remove Barriers to Using Local Care

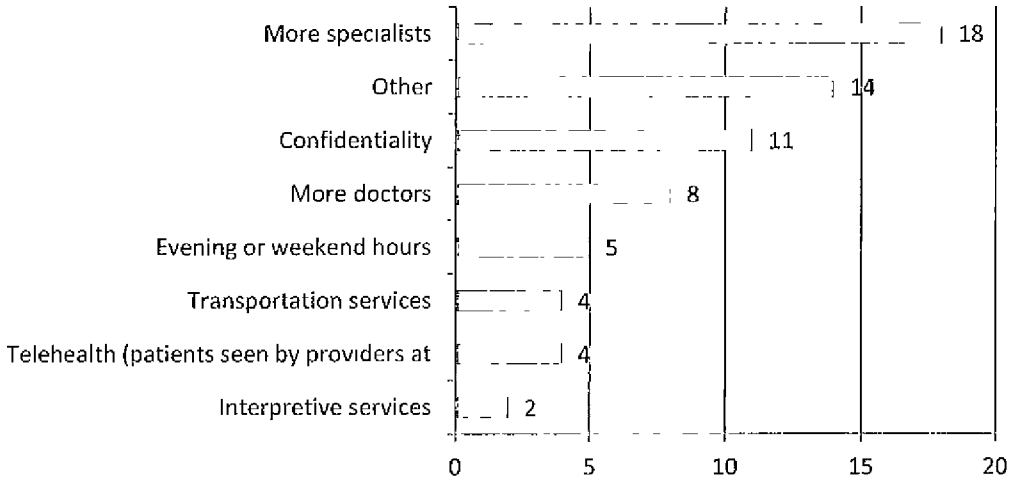
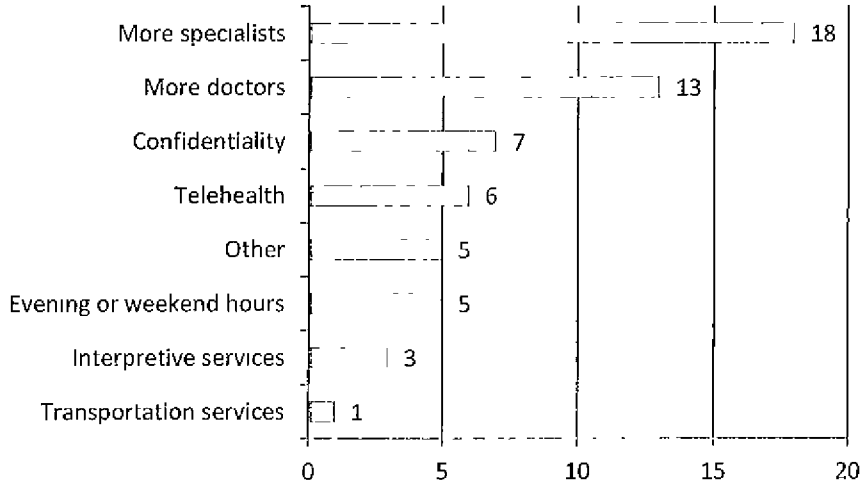


Figure 36: Health Care Professionals' Recommendations to Help Remove Barriers to Using Local Care



Concerns and Suggestions for Improvement

Each version of the survey concluded with an open-ended question that asked, "Overall, please share concerns and suggestions to improve the delivery of local health care." Responses were supplied by 19 community members and nine health care professionals. Of the 28 responses, the most common (N=8) were expressions of appreciation for, or satisfaction with, CMC, its providers, and its services. Other common responses

included requests for more support (financially and otherwise) for hospital staff (N=3), customer service concerns (N=3, with two specifically mentioning billing concerns), and concerns about overall management of the hospital (N=3).

Below are some of the specific comments given in response to this open-ended question:

- A reliable female doctor or FNP or PA would benefit us Also someone who has an emphasis with children.
- I feel like we have just become a number and truly not cared for 100%. Doctors are moving in and out so fast, you don't really get a chance to know much about them or them about you.
- I think our hospital is doing a fantastic job!
- Never impressed with the billing situation. Still haven't received from over six months ago! While doctoring elsewhere, I receive a bill within a month.
- The only priority I see is more assisted living apartments A list that has 40 names on it is too long for a community this size
- We have excellent health care providers.
- Better administrative communication with direct patient care staff and community. Overall, very proud and pleased with our local accomplishments, but communication with community and "lower level" staff is lacking somewhat. More community involvement and educational opportunities would be appreciated.
- Better advertising. I believe the quality of care being provided is excellent --people just need to know exactly what services are offered in their own town.
- CMC is doing a great job! Glad to have this place. Minor suggestions: I think that more community outreach - bringing services to the residents of Cooperstown would bring more awareness of the hospital (screenings, health fairs, speakers, etc); collaborate with public health to get into the schools, daycares, business wellness programs, etc ; more hospital presence on local boards/committees.
- I feel we have had some very good health care providers at this facility, which is a blessing. Our continual financial struggle is always a concern.

Collaboration

Respondents were asked whether Cooperstown Medical Center could improve its levels of collaboration with other local entities, such as schools, economic development organizations, local businesses, public health, other providers, and hospitals in other cities. Of the three answer choices ("Yes," "No, it's fine as is," "Don't know"), community members were fairly evenly split between choosing "Yes" and "No, it's fine as is." Community members were more likely to see room for improvement with regard to CMC's collaboration with other local health providers, hospitals and clinics in other cities, and schools.

Health care professionals were more likely to say that collaboration could be improved than not with respect to five of the six potential collaborators; with regard to the sixth, business and industry, they were evenly split. Health care professionals saw the most need for collaboration with schools and hospitals and clinics in other cities. Figures 37 and 38 illustrate these results.

Figure 37: Community Members – Could Cooperstown Medical Center Improve Collaboration?

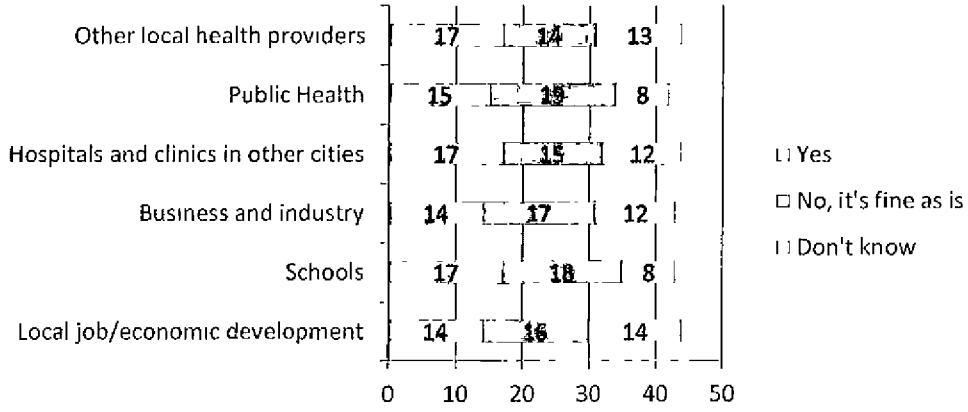
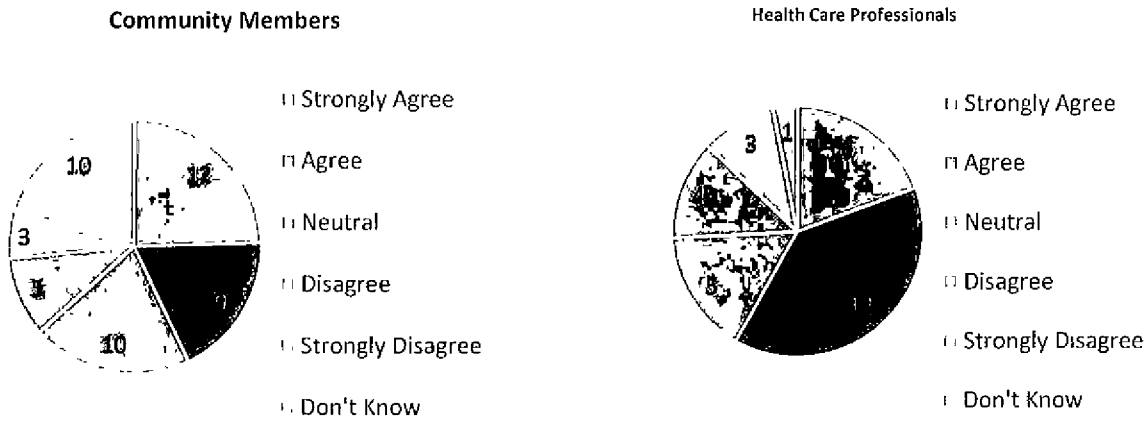


Figure 38: Health Care Professionals – Could Cooperstown Medical Center Improve Collaboration?

Affiliation with Larger Health System

Respondents were informed that "Cooperstown Medical Center may consider the possibility of aligning with a larger health system," and then asked whether they agreed that this idea is worth considering. As shown in Figure 39, a plurality (N=12) of community members "strongly agreed" that this was an idea worth considering, while a much small number of respondents (N=3) "strongly disagreed." Considerably more community members (N=21) either strongly agreed or agreed that the idea was worth considering as compared to the number of respondents (N=8) who either strongly disagreed or disagreed. The same general consensus emerged with respect to health care professionals responding to this question. More than half (N=18) either strongly agreed or agreed that alignment with a larger health system is an idea worth considering. On the other hand, a larger proportion of health care professionals (N=7) either strongly disagreed or disagreed as compared to community members who either strongly disagreed or disagreed. In both groups, there were several respondents who were neutral on this issue.

Figure 39: Do You Agree that CMC's Alignment with a Larger Health System is an Idea Worth Considering?



Findings from Key Informant Interviews and Focus Group

The questions posed in the survey also were explored during a focus group session with the Community Group as well as during key informant interviews with community leaders and a public health professional. Several themes emerged from these sessions. Many of the same issues that were prevalent in the survey results also emerged during the focus group and key informant interviews (and were further explored during the discussions), but additional issues also appeared. Generally, overarching thematic issues that developed during the interviews can be grouped into four categories (listed in no particular order):

1. Need for mental health services
2. Uninsured not getting care/low awareness of community care
3. Financial viability of hospital
4. Maintaining emergency medical services

A more detailed discussion about these other noteworthy issues follows:

1. Need for mental health services

Participants identified several mental health needs in the community, including depression, anxiety, suicide, and Alzheimer's disease. While some participants were aware of services provided by visiting mental health professionals, others did not know such services were available locally. Among those aware of local mental health services, several believed that the services were not offered with enough frequency.

Multiple participants talked about the stigma associated with mental health disease and how changing attitudes toward the treatment of mental health issues would result in more people getting the help they need.

Specific comments included:

- There might be some gaps in how to work together to meet mental health services. It's hard to differentiate all these concerns because mental health needs are so broad.
- The psychologist is only here every 2 weeks. It'd be better if he came more often. There are lots of mental health needs: depression, anxiety, suicide. There was a suicide here in the high school a year ago.
- I'm worried about the mental health of youth. There have been some teen suicides recently.
- There is a definite need for more mental health, and there's still so much stigma.
- With mental health issues, people don't want to go where others will find out they have a mental illness. Even though it's no different than any other illness, there is still a stigma.
- Mental health needs are being met, at least it some ways. There is a visiting psychologist and guidance counselors at the school.
- Mental health is an issue. If people are more open about it and talk about it, it takes away the stigma.
- There's a stigma with mental health that's hard to change. If there's a change to the stigma, more people might get treatment.
- I just recently learned about the psychologist visiting here. I heard about it through word of mouth.
- There is lots of depression in school-aged children and older people. Long winters take a toll and Scandinavians aren't always good at asking for help
- Alzheimer's is becoming more and more common.

2. Uninsured not getting care/low awareness of community care

Focus group and interview participants pointed to the existence of financial barriers that likely are preventing area residents from receiving health care services. Participants pointed to issues associated with having no insurance as well as to issues connected to rising insurance premiums and co-pays. A particular concern that arose was the perceived lack of awareness of charity care among people who lack adequate financial resources to pay for health care services for themselves or family members.

These voiced concerns are consistent with the overall results of survey, which showed that among both community members and health care professionals, higher costs of health care for consumers was ranked as the second most important community health concern among 16 listed concerns. Among both groups of respondents, only financial viability of the hospital topped cost concerns among potential health concerns.

The survey also asked community members about their health insurance status. Of the 60 respondents who answered the question, a large majority had insurance through an employer, private insurance, or Medicare. Only three respondents indicated they had no health insurance. It is important to note, though, that the survey sample may not be a representative sample of the residents of the CMC service area and that this expressed concern is valid. While few survey respondents indicated they themselves lacked insurance, among key informant interviews were those who worked with vulnerable populations and have noted the struggles of those who lack insurance and experience other financial barriers to receiving proper health care.

Specific comments from participants included:

- There are more people moving into Griggs County who are uninsured, so more people may need to seek out financial assistance.
- CMC might need to do more to promote community care, but it is a fine line to walk because you want to promote it without encouraging people to take advantage of the system. It is so important to have it for people who truly need it.
- Not having insurance or not being able to afford health care – and Medicaid only covers certain categories of people. Even if people can be seen by a provider, they might not be able to afford a prescription.
- Some people are not aware of the availability of charity care/community care, especially people who might need help paying for meds.

- A portion of the population is uninsured I think some people just won't need services and others just know they'll be able to get care if they need it.
- I'm not sure of what charity care is available.
- People without insurance might wait longer to get care, but they're probably on Medicaid.
- Community care provides severely discounted medical care. Many people are not aware of it.

3. Financial viability of hospital

As noted above, the top potential health concern among both community members and health care professionals taking the survey was the financial viability of the hospital. Focus group and interview participants echoed this concern with regularity. They also noted the importance of the hospital not only as a point of access to medical care, but also as a major employer in the community.

The potential alignment of CMC with a larger health system often was brought up in connection with concerns about the hospital's viability. While survey respondents generally were favorable toward consideration of the idea of CMC aligning with a larger system, some interviewees and focus group members voiced concerns about the possibility, with one noting, "The problem with being part of a bigger system is that someone from the outside can come in and make decisions just looking at the bottom line. They try to impose a one-size-fits-all approach That doesn't work with healthcare." Another said that the community "is proud to have a locally controlled facility." Others were more enthusiastic about the idea or more resigned to the reality of it. As one said, "I don't think this would be a shock to anyone. People would take time to get used to it The writing's on the wall – it's inevitable. We need to be open and keep the medical facility in town." One participant offered advice should CMC align with a larger system: "The community might buy into it better if it were sold and marketed as a need to collaborate to offer services. But initially it would have to be sold to people."

Participants' comments included:

- Financial viability of the hospital is the most important – we need to keep it here.
- There is a big perception problem about whether the hospital is financial viable

- Aligning with a larger system might bring more financial stability But would we lose jobs? Would we lose doctors and CNAs? Would they take away services? It's never good to lose what you already have.
- The facility is not only important in terms of health care, but it is a huge employee base. It's a significant payroll in the community.

4. Maintaining emergency medical services

Emergency medical services were mentioned by several participants, with some specifically making note of the burdens a volunteer squad places on the individual volunteers Participants highlighted the critical aspect of EMS in a rapidly unfolding emergency situation, and it was perceived as an absolute "must-have" in the community.

Specific comments included:

- We've got to have emergency services In a rural area there's no time to get to Fargo or Jamestown.
- We have struggled to find EMS workers and volunteers. They have a lot more runs than people understand.
- EMS volunteers. There are not enough, so those on call get worn out We always need more people to do EMT and first responder classes.
- Need to have good emergency services.
- Keeping EMS services. Not having those services will be a barrier to care. People on the squad now are really stretched. Many of them have young families There's been a plea to get more people to take the training to become volunteers
- EMS is the most important concern.

Additional Issues

Other issues that did not emerge as themes, but were mentioned, may warrant additional consideration. These other comments include:

- More of the free preventive fairs would be a good thing, especially with the elderly population. The health fair is always busy.
- It would be awesome to have a nurse that could go into homes and help with meds Some people are shut in and don't know what's going on

- It would be nice to have a female doctor here more often; it would be nice to have them more than twice a month for women, and for girls for sports physicals.
- One of the biggest concerns is the billing system. It concerns a lot of people. It can take 60 to 90 days to get a bill for a simple procedure.

Priority of Health Needs

The Community Group held its second meeting on October 18, 2012. Fifteen members of the group attended the meeting. A representative from the Center for Rural Health presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the results of the survey (including perceived community health and community concerns, awareness of local services, why patients seek care at CMC, community collaboration, and barriers to care), and findings from the focus group and key informant interviews.

Following the presentation of the assessment findings, and after careful consideration of and discussion about the findings, each member of the group was asked to identify on a ballot what they perceived as the top five community health needs. Based on the Community Group's feedback about the prioritization of community health needs, the needs were categorized into four tiers: those receiving five or more votes, those receiving three or four votes, those receiving one or two votes, and those receiving no votes. Concerns comprising the top two tiers were:

<u>Tier 1</u>

- Financial viability of hospital (8 votes)
- Maintaining emergency medical services (5 votes)

<u>Tier 2</u>

- Elevated rate of excessive drinking (4 votes)
- Cost of health care (4 votes)
- Cancer (4 votes)
- Aging population (4 votes)
- Elevated rate of uninsured residents (3 votes)
- Adequate number of providers/specialists (3 votes)
- Declining population (3 votes)
- Lack of employment opportunities/low wages (3 votes)

A summary of this categorization may be found in Appendix H. This prioritization of needs will serve as guide to CMC as it plans for the future and works on a strategic implementation to meet community needs.

Summary

This study took into account input from approximately 92 community members and health care professionals from multiple communities as well as 34 individuals who are leaders in, or active in, the community. This input represented the broad interests of the community served by Cooperstown Medical Center. Together with secondary data gathered from a wide range of sources, the information gathered presents a snapshot of health needs and concerns in the community.

An analysis of secondary data reveals that the primary portion of CMC service area – Griggs and Steele counties – has a higher percentage of adults over the age of 65 and a higher median age than the state average, with more than one in four residents aged 65 or older in Griggs County and more than one in five residents aged 65 and older in Steele County. This likely indicates increased need for medical services to attend to an aging population. This concern was echoed by community members and health care professionals, who through the survey collectively ranked the aging population as the most important general community concern.

The data compiled by County Health Rankings shows that Griggs County is performing below the state average on a few of the measures examined: physical inactivity, uninsured residents, mental health provider ratio, and limited access to healthy foods Griggs County also was not measuring up to the County Health Rankings' national benchmarks on other factors: adult smoking, adult obesity, excessive drinking, sexually transmitted infections, and preventable hospital stays. Notably, the county's rate of excessive drinking was more than twice national benchmark On the positive side, Griggs County was meeting the national benchmark (meaning it is performing in the top 10% of counties nationally) in terms of the ratio of residents to primary care providers, diabetic screening, access to recreational facilities, and prevalence of fast food restaurants.

Steele County performed worse than Griggs County on a number of the measures analyzed by County Health Rankings and was not meeting the state averages on the following measures: adult smoking, adult obesity, physical inactivity, mental health provider ratio, limited access to healthy foods, and limited access to recreational

facilities. The rates in Steele County of adult smoking, adult obesity, and physical inactivity were substantially higher than the national benchmarks. On the positive side, Steele County was besting the national benchmark on the measures of sexually transmitted infections, diabetic screening, and prevalence of fast food restaurants

Results from the survey revealed that among community members the top five general community concerns were: (1) aging population, (2) declining population, (3) lack of employment opportunities, (4) low wages, lack of livable wages, and (5) maintaining enough health care workers. Health care professionals chose the same five top concerns, although they ranked maintaining enough health care workers higher and declining population lower. They agreed with community members that the aging population was the most important community concern

When asked about potential community health needs, community members placed as the top five concerns the financial viability of the hospital, higher costs of health care for consumers, heart disease, cancer, and suicide prevention. Health care professionals agreed that the top two health concerns were financial viability of the hospital and higher costs of health care for consumers. Rounding out health care professionals' top five concerns were not enough health care staff in general, adequate number of providers/specialists, and mental health.

The survey also revealed generally wide awareness of most locally available health care services and that residents choose to receive care locally due to convenience, familiarity with providers, and proximity. Residents travel out of the area for service primarily for access to necessary specialists and because of perceived high quality care.

Input from Community Group members and community leaders echoed many of the concerns raised by survey respondents, and also highlighted concerns about (1) the need for mental health services, (2) uninsured residents not getting care and not being aware of community care, (3) the financial viability of the hospital, and (4) maintaining EMS services.

Following careful consideration of the results and findings of this assessment, Community Group members determined that the top health needs or issues in the community are the financial viability of the hospital and maintaining emergency medical services.

Appendix A1 – Community Member Survey Instrument

Center for Rural Health
The University of North Dakota School of Medicine & Health Sciences

CMC

Community Member Health Needs Survey

Cooperstown Medical Center is interested in hearing from you about area health needs. The Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences is administering this survey on behalf of Cooperstown Medical Center. This initiative is funded by the N.D. Medicare Rural Hospital Flexibility Program. The focus of the assessment is to:

- Learn about the community's concerns and hear suggestions for improvement
- Learn of the community's awareness of local health care services being provided
- Determine preferences for using local health care services versus traveling to other facilities

Please take a few moments to complete the survey. If you prefer, this survey may be completed online by visiting: www.surveymonkey.com/s/cooperstown. Your responses are anonymous – and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported in aggregate form. If you have questions about the survey, you may contact Ken Hall at the Center for Rural Health, 701.777.6046, kenneth.hall@med.und.edu.

Surveys will be accepted through August 24, 2012. Your opinion matters. Thank you in advance!

Community Concerns

Q1a. Regarding the conditions in your community, please rank each of the potential concerns on a scale of 1 to 5, with 1 being less of a concern and 5 being more of a concern:

Community concerns	Less of a concern 1	2	3	4	More of a concern 5
Aging population, lack of resources to meet growing needs					
Alcohol and drug use and abuse					
Crime and community violence					
Declining population, including residents moving away					
Domestic violence, including child abuse					
Impact of increased oil/energy development					
Insufficient facilities for exercise and well-being					
Lack of affordable housing					
Lack of employment opportunities					
Lack of police presence in community					
Low wages, lack of livable wages					
Maintaining enough health workers (e.g., medical, dental, wellness)					
Poverty					
Racism, prejudice, hate, discrimination					
Taxes					
Traffic safety, including speeding and drunk driving					
Other. Please specify:					

b) Which concern above is the most important? _____

c) Why is that concern the most important? _____

_____

Health Care Services

Regarding each of the following health care services, please tell us:

a) Whether you are aware that the health care service is offered at Cooperstown Medical Center (CMC).
b) Whether you have used the health care service at Cooperstown Medical Center (CMC), at another facility, or both

Q2a. General services

a) Aware of services at CMC?		Type of service offered	b) Used services, either at CMC or another facility? (Check both if applicable)	
Yes	No		Used Services at CMC	Used Services at Another Facility
		Assisted living		
		Clinic		
		Community education		
		Hospice		
		Lifeline		
		Meals on wheels		
		Respite care		
		Swing bed services		
		Visiting specialists – cardiology		
		Visiting specialists – podiatry		
		Visiting specialists – psychology		
		Visiting specialists – urology		

Q2b. Screening/therapy services

a) Aware of services at CMC?		Type of service offered	b) Used services, either at CMC or another facility? (Check both if applicable)	
Yes	No		Used Services at CMC	Used Services at Another Facility
		Holter monitor		
		Immunizations		
		Laboratory services		
		Nutrition counseling		
		Occupational therapy/speech therapy		
		Physical therapy		
		Pulmonary function testing		

Q2c Acute services

a) Aware of services at CMC?		Type of service offered	b) Used services, either at CMC or another facility? (Check both if applicable)	
Yes	No		Used Services at CMC	Used Services at Another Facility
		Cardiac services/rehab		
		Emergency room		
		Hospital (acute care)		
		Minor surgical procedures		

Q2d Radiology services

a) Aware of services at CMC?		Type of service offered	b) Used services, either at CMC or another facility? (Check both if applicable)	
Yes	No		Used Services at CMC	Used Services at Another Facility
		Radiology – bone-density		
		Radiology – CT scan		
		Radiology – general x-ray		
		Radiology – mammography		
		Radiology – ultrasound		

Q2e. What specific services, if any, do you think Cooperstown Medical Center needs to add, and why?

_____

_____

Q3 Regarding the following health care services offered by <u>providers other than CMC</u> please tell us.

a) Whether you are aware of the health care services offered locally.

b) Whether you have used the health care services locally, out of the area, or both.

a) Aware of services offered locally?		Type of service offered	b) Used services, either locally or non-locally? (Check both if applicable)	
Yes	No		Used Services Locally	Used Services Non-Locally
		Dental services		
		Hearing aid services		
		Nursing home care center		
		Optometric/vision services		
		WIC (Women, Infants, Children) program		

Delivery of Health Care

Q4 Regarding the delivery of health care in your community, please rank each of the potential health concerns listed below on a scale of 1 to 5, with 1 being less of a concern and 5 being more of a concern.

Health concerns	Less of a concern 1	2	3	4	More of a concern 5
Access to needed technology/equipment					
Accident/injury prevention					
Addiction/substance abuse					
Adequate number of health care providers and specialists					
Cancer					
Diabetes					
Distance/transportation to health care facility					
Emergency services (ambulance & 911) available 24/7					
Financial viability of hospital					
Focus on wellness and prevention of disease					
Heart disease (e g , congestive heart failure, heart attack, stroke, coronary artery disease)					
Higher costs of health care for consumers					
Mental health (e.g., depression, dementia/Alzheimer's)					
Not enough health care staff in general					
Obesity					
Suicide prevention					

b) Which concern above is the most important? _____

c) Why is that concern the most important? _____

_____.

Q5. Please tell us why you seek health care services at Cooperstown Medical Center. (Choose ALL that apply)

- ☐ Confidentiality
- ☐ Disability access
- ☐ Access to specialist
- ☐ Less costly
- ☐ Proximity
- ☐ Open at convenient times
- ☐ Familiarity with providers
- ☐ They take my insurance
- ☐ They take new patients
- ☐ Transportation is readily available
- ☐ Convenience
- ☐ High quality of care
- ☐ Loyalty to local service providers
- ☐ Other. (Please specify)_____

Q6 Please tell us why you seek health care services at another health care facility (Choose ALL that apply)

- ☐ Confidentiality
- ☐ Disability access
- ☐ Provides necessary specialists
- ☐ Less costly
- ☐ Open at convenient times
- ☐ They take many types of insurance
- ☐ They take new patients
- ☐ Transportation is readily available
- ☐ High quality of care
- ☐ Other (Please specify)_____

Q7 What would help to address the reasons why you do not seek health care services in the Cooperstown area? (Choose ALL that apply.)

- ☐ Confidentiality
- ☐ Evening or weekend hours
- ☐ Interpretive services
- ☐ Telehealth (patients seen by providers at another facility through a monitor/TV screen)
- ☐ More doctors
- ☐ More specialists
- ☐ Transportation services
- ☐ Other. (Please specify)_____

Q8. How long does it take you to reach the nearest clinic?

- ☐ Less than 10 minutes
- ☐ 10 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ More than 1 hour

Q9. How long does it take you to reach Cooperstown Medical Center?

- ☐ Less than 10 minutes
- ☐ 10 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ More than 1 hour

Q10. Do you believe that Cooperstown Medical Center should improve its collaboration with:

	Yes	No. It's fine as it is.	Don't know
a) Local job/economic development	☐	☐	☐
b) Schools	☐	☐	☐
c) Business and industry	☐	☐	☐
d) Hospitals and clinics in other cities	☐	☐	☐
e) Public Health	☐	☐	☐
f) Other local health providers	☐	☐	☐

Q11 Cooperstown Medical Center may consider the possibility of aligning with a larger health system. Do you agree that this idea is worth considering?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ Don't Know

SURVEY CONTINUES ON NEXT PAGE.

Demographic Information

Please tell us about yourself.

Q12. Listed below are some general health conditions/diseases. Please select all that apply to you.

- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Cancer
- ☐ Chronic pain
- ☐ Dementia
- ☐ Depression, stress, etc
- ☐ Muscles or bones (e.g., back problems, broken bones)
- ☐ Heart conditions (e.g., congestive heart failure)
- ☐ High cholesterol
- ☐ Hypertension
- ☐ OB/Gyn related
- ☐ Weight control
- ☐ Diabetes

Q13 Health insurance status (Choose all that apply)

- ☐ Insurance through employer
- ☐ Private insurance
- ☐ Tribal insurance
- ☐ Indian Health Services
- ☐ Medicare
- ☐ Medicaid
- ☐ Veteran's Health Care Benefits
- ☐ No health insurance
- ☐ Other

Q14. Age.

- ☐ Less than 25 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years and older

Q15. Highest level of education.

- ☐ Some high school
- ☐ High school diploma or GED
- ☐ Some college/technical degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate or professional degree

Q16 Gender:

- ☐ Female
- ☐ Male

Q17. Your zip code: _____

Q18. Marital status:

- ☐ Divorced/separated
- ☐ Married
- ☐ Single/never married
- ☐ Widowed

Q19. Employment status.

- ☐ Full time
- ☐ Part time
- ☐ Homemaker
- ☐ Multiple job holder
- ☐ Unemployed
- ☐ Retired

Q20. Annual household income before taxes:

- ☐ $0 to $14,999
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 to $199,999
- ☐ $200,000 and over
- ☐ Prefer not to answer

Q21. Overall, please share concerns and suggestions to improve the delivery of local health care.

Thank you for assisting us with this important survey!

6

Appendix A2 – Health Care Professional Survey Instrument

Cooperstown Area Health Needs Survey - Health Care Professionals

Community Concerns

As you may know, Cooperstown Medical Center is in the process of conducting a community health needs assessment. Health care professionals and community members are being asked to complete a survey. The Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences is administering this survey on behalf of St. Andrew's Health Center. This initiative is sponsored by the N.D. Medicare Rural Hospital Flexibility Program. The focus of the assessment is to:

- Learn about the community's assets and concerns, and hear suggestions for improvement
- Learn of the community's awareness of local health care services being provided
- Determine preferences for using local health care services versus traveling to other facilities

Please take a few moments to complete the survey. The survey has 16 QUESTIONS on 3 PAGES.

Your responses are anonymous – and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported in aggregate form. If you have questions about the survey, you may contact Ken Hall at the Center for Rural Health, 701 777 6046, kenneth.hall@med.und.edu

Cooperstown Area Health Needs Survey - Health Care Professionals

1. Regarding the conditions in your community, please rank each of the potential concerns listed below on a scale of 1 to 5, with 1 being less of a concern and 5 being more of a concern

	1 - Less of a concern	2	3	4	5 - More of a concern
Aging population, lack of resources to meet growing needs	◯	◯	◯	◯	◯
Alcohol and drug use and abuse	◯	◯	◯	◯	◯
Crime and community violence	◯	◯	◯	◯	◯
Declining population, including residents moving away	◯	◯	◯	◯	◯
Domestic violence, including child abuse	◯	◯	◯	◯	◯
Impact of increased oil/energy development	◯	◯	◯	◯	◯
Insufficient facilities for exercise and well-being	◯	◯	◯	◯	◯
Lack of affordable housing	◯	◯	◯	◯	◯
Lack of employment opportunities	◯	◯	◯	◯	◯
Lack of police presence in community	◯	◯	◯	◯	◯
Low wages, lack of livable wages	◯	◯	◯	◯	◯
Maintaining enough health workers (e.g., medical, dental, wellness)	◯	◯	◯	◯	◯
Poverty	◯	◯	◯	◯	◯
Racism, prejudice, hate, discrimination	◯	◯	◯	◯	◯
Taxes	◯	◯	◯	◯	◯
Traffic safety including speeding and drunk driving	◯	◯	◯	◯	◯
Other (please specify)					

2. Which concern listed above is the most important, and why?

Cooperstown Area Health Needs Survey - Health Care Professionals

Delivery of Health Care

3. Regarding the delivery of health care IN YOUR COMMUNITY, please rank each of the potential health concerns listed below on a scale of 1 to 5, with 1 being less of a concern and 5 being more of a concern:

	1 - Less of a concern	2	3	4	5 - More of a concern
Access to needed technology/equipment	◯	◯	◯	◯	◯
Accident/injury prevention	◯	◯	◯	◯	◯
Addiction/substance abuse	◯	◯	◯	◯	◯
Adequate number of health care providers and specialists	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯
Distance/transportation to health care facility	◯	◯	◯	◯	◯
Emergency services (ambulance & 911) available 24/7	◯	◯	◯	◯	◯
Financial viability of hospital	◯	◯	◯	◯	◯
Focus on wellness and prevention of disease	◯	◯	◯	◯	◯
Heart disease (e g , congestive heart failure, heart attack, stroke, coronary artery disease)	◯	◯	◯	◯	◯
Higher costs of health care for consumers	◯	◯	◯	◯	◯
Mental health (e g., depression, dementia/Alzheimer's)	◯	◯	◯	◯	◯
Not enough health care staff in general	◯	◯	◯	◯	◯
Obesity	◯	◯	◯	◯	◯
Suicide prevention	◯	◯	◯	◯	◯

Which concern is the most important, and why?

Cooperstown Area Health Needs Survey - Health Care Professionals

4. Please tell us why you think patients seek health care services at Cooperstown Medical Center. (Choose ALL that apply.)

- ☐ Confidentiality
- ☐ Disability access
- ☐ Access to specialist
- ☐ Less costly
- ☐ Proximity
- ☐ Open at convenient times
- ☐ Familiarity with providers
- ☐ We take their insurance
- ☐ We take new patients
- ☐ Transportation is readily available
- ☐ Convenience
- ☐ High quality of care
- ☐ Loyalty to local service providers
- ☐ Other (please specify in the box below)

5. Please tell us why you think patients seek health care services AT ANOTHER HEALTH CARE FACILITY. (Choose ALL that apply.)

- ☐ Confidentiality
- ☐ Disability access
- ☐ Provides necessary specialists
- ☐ Less costly
- ☐ Open at convenient times
- ☐ Other (please specify in the box below)
- ☐ Takes many types of insurance
- ☐ Takes new patients
- ☐ Transportation is readily available
- ☐ High quality of care

6. What would help to address the reasons why patients do not seek health care services in the Cooperstown area? (Choose ALL that apply.)

- ☐ Confidentiality
- ☐ Evening or weekend hours
- ☐ Interpretive services
- ☐ Telehealth (patients seen by providers at another facility through a monitor/TV screen)
- ☐ Other (please specify in the box below)
- ☐ More doctors
- ☐ More specialists
- ☐ Transportation services

Cooperstown Area Health Needs Survey - Health Care Professionals

7. What specific services, if any, do you think Cooperstown Medical Center needs to add, and why?

8. Do you seek health care services outside of the area? If so, why?

9. Do you believe that Cooperstown Medical Center could improve its collaboration with:

	Yes	No, it's fine as it is	Don't know
Local job/economic development	◯	◯	◯
Schools	◯	◯	◯
Business and industry	◯	◯	◯
Hospitals and clinics in other cities	◯	◯	◯
Public Health	◯	◯	◯
Other local health providers	◯	◯	◯

10. Cooperstown Medical Center may consider the possibility of aligning with a larger health system. Do you agree that this idea is worth considering?

- ◯ Strongly agree
- ◯ Agree
- ◯ Neutral
- ◯ Disagree
- ◯ Strongly disagree
- ◯ Don't know
- ◯ Other (Please specify other capital improvements that you believe the community would financially support)

Cooperstown Area Health Needs Survey - Health Care Professionals

Demographic Information

Please tell us about yourself

11. Age:

- ◯ Less than 25 years
- ◯ 25 to 34 years
- ◯ 35 to 44 years
- ◯ 45 to 54 years
- ◯ 55 to 64 years
- ◯ 65 to 74 years
- ◯ 75 years and older

12. Highest level of education:

- ◯ Some high school
- ◯ High school diploma or GED
- ◯ Some college/technical degree
- ◯ Associate's degree
- ◯ Bachelor's degree
- ◯ Graduate or professional degree

13. Gender:

- ◯ Female
- ◯ Male

14. Profession:

- ◯ Clerical
- ◯ Health care administration
- ◯ Allied health professional
- ◯ Environmental services
- ◯ Nurse
- ◯ Physician
- ◯ Physician's Assistant/Nurse Practitioner
- ◯ CNA/Other assistant

Other (please specify in the box below)

_____

15. How long have you been employed or in practice in the area?

- ◯ Less than 5 years
- ◯ 5 to 10 years
- ◯ More than 10 years

Other (please specify in the box below)

_____

_____

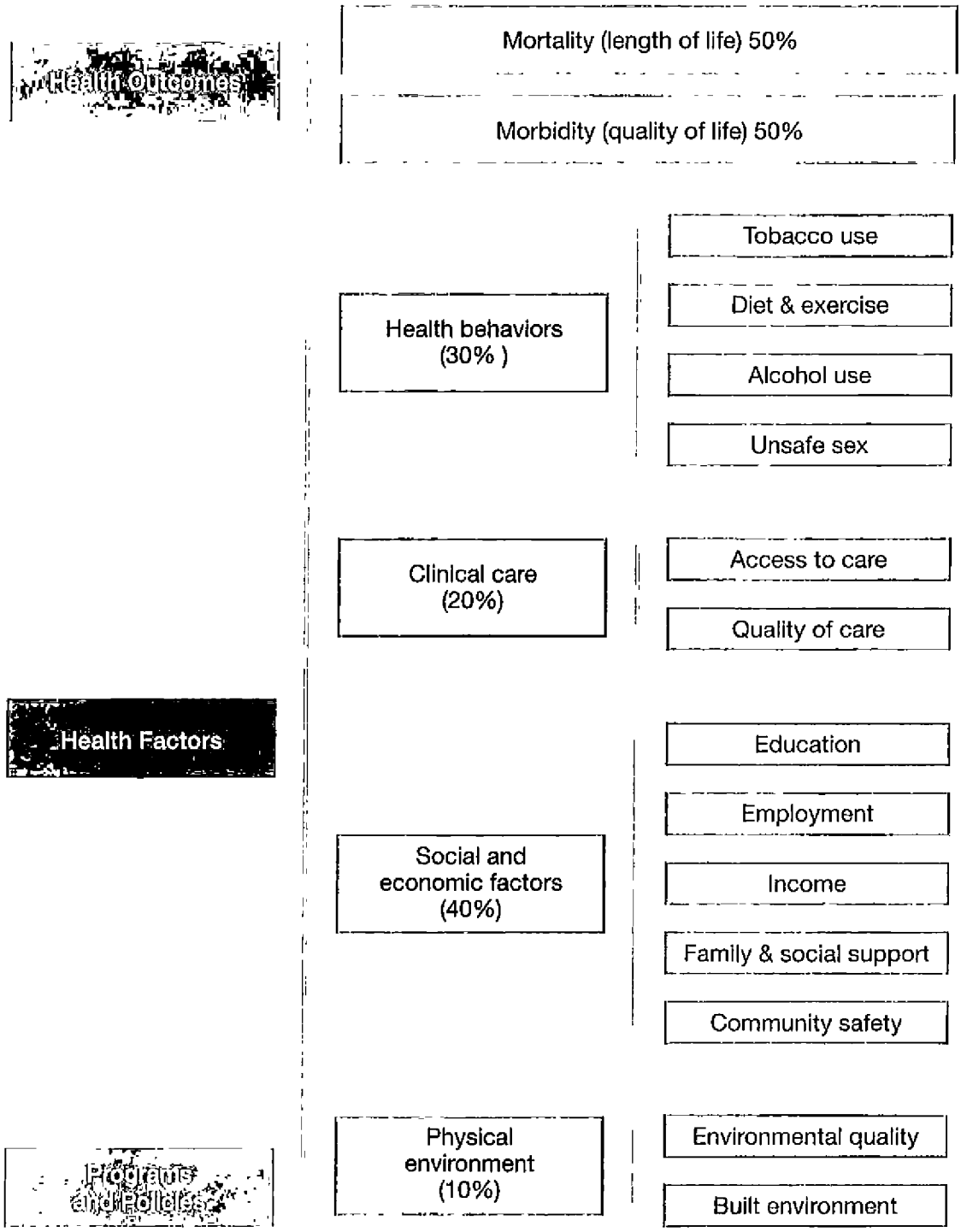
Cooperstown Area Health Needs Survey - Health Care Professionals

16. Overall, please share concerns and suggestions to improve the delivery of local health care.

Appendix F – Community Group Members and Key Informants

NAME	TITLE	ORGANIZATION
Diane Cowdrey	Librarian & County Commissioner	Griggs County Library & Griggs County
Jan Erickson	Retired	
Sheridan Erickson	Banker	Citizens State Bank
David Evans	Retired	
Ruth Evans	Retired	
Donna Evers	CMC Board Treasurer	Cooperstown Medical Center
Julie Ferry	Administrator, Director of Nursing	Nelson-Griggs District Health Unit
Helene Fossum	Chairperson	Griggs County Care Center
Cia Gronneberg	Licensed Social Worker	Griggs County Social Services
Paulette Gronneberg	Corporate Compliance Officer	Cooperstown Medical Center
JoAnn Hagle	Retired	
Kevin Jacobson	FNP-C	Cooperstown Medical Center
Lois Johnson	Retired	
Mildred Kirkeby	Resident	Griggs County Care Center
Lois Knudson	Retired	
Sherry Lind	Editor	Griggs County Courier
Harry Lipsiea	Editor	Griggs County Courier
Connie Loge	Retired	
David Lunde	Retired	
Nathan Lunde	RN	Mercy Hospital - Valley City
Marybeth Lunde	School Aide	Griggs County School
Brad McCullough	Market President/VP	Bank Forward
Norma Olson	Retired	
Paul Paintner	Business Owner	Pizza Ranch
Phyllis Radcliffe	Attorney	Radcliffe Law Office
Ken Smith	CFO	Cooperstown Medical Center
Bonnie Smith	Retired	
Greg Stomp	CEO/Administrator	Cooperstown Medical Center
Connie Swenson	Executive Assistant	Cooperstown Medical Center
Don Vigesaa	Business Owner/State Legislator	V-W Motors/State of ND
George Vigesaa	Retired Farmer	
Muriel Vigesaa	Retired	
Ted Vigesaa	Retired	
Joanne White	Chairperson	County Hospital District

Appendix C – County Health Rankings Model



County Health Rankings model ©2010 UWPHI

Appendix D – Definitions of Health Variables

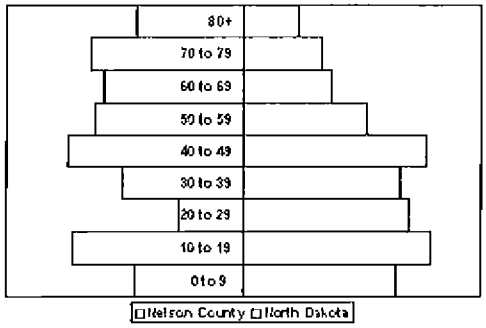
Definitions of Health Variables from the *County Health Rankings 2011 Report*

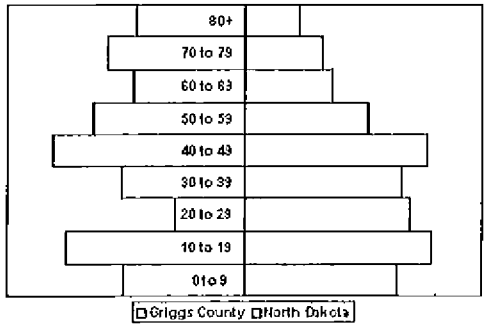
Variable	Definition
Poor or Fair Health	Self-reported health status based on survey responses to the question "In general, would you say that your health is excellent, very good, good, fair or poor?"
Poor Physical Health Days (in past 30 days)	Estimate based on responses to the question "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"
Poor Mental Health Days (in past 30 days)	Estimate based on responses to the question "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
Adult Smoking	Percent of adults that report smoking equal to, or greater than, 100 cigarettes and are currently a smoker
Adult Obesity	Percent of adults that report a BMI greater than or equal to, 30
Excessive Drinking	Percent of as individuals that report binge drinking in the past 30 days (more than 4 drinks on one occasion for women, more than 5 for men) or heavy drinking (defined as more than 1 (women) or 2 (men) drinks per day on average
Sexually Transmitted Infections	Chlamydia rate per 100,000 population
Teen Birth Rate	Birth rate per 1,000 female population, ages 15-19
Uninsured Adults	Percent of population under age 65 without health insurance
Preventable Hospital Stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Mammography Screening	Percent of female Medicare enrollees that receive mammography screening
Access to Healthy Foods	Healthy food outlets include grocery stores and produce stands/farmers' markets
Access to Recreational Facilities	Rate of recreational facilities per 100,000 population
Diabetics	Percent of adults aged 20 and above with diagnosed diabetes
Physical Inactivity	Percent of adults aged 20 and over that report no leisure time physical activity
Primary Care Provider Ratio	Ratio of population to primary care providers
Mental Health Care Provider Ratio	Ratio of population to mental health care providers
Diabetic Screening	Percent of diabetic Medicare enrollees that receive HbA1c screening
Binge Drinking	Percent of adults that report binge drinking in the last 30 days. Binge drinking = consuming more than 4 (women) or 5 (men) alcoholic drinks on one occasion

Nelson and Griggs Community Health Profiles

POPULATION

Population by Age Group, 2000 Census								
Age Group	Nelson County		Griggs County		NGDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-9	337	9 1	282	10 2	619	10 2	82,382	12 8%
10-19	534	14 4	412	15 0	946	15 0	101,082	15.7%
20-29	200	5 4	160	5 8	360	5 8	89,295	13 9%
30-39	378	10 2	283	10 3	661	10 3	85,086	13 2%
40-49	548	14 8	443	16 1	991	16 1	98,449	15 3%
50-59	465	12 5	349	12 7	814	12 7	66,921	10 4%
60-69	439	11 8	259	9 4	697	9 4	47,649	7 4%
70-79	478	12 9	316	11 5	794	11 5	41,844	6 5%
80+	336	9 0	251	9 1	587	9 1	29,492	4 6%
Total	3715	100 0	2754	100 0	6,469	100 0	642,200	100 0%
0-17	820	22 1%	621	22 5%	1,441	22 3%	160,849	25 0%
65+	1,019	27 4%	708	25 7%	1,727	26 7%	94,478	14.7%





Female Population and Percentage Female by Age, 2000 Census								
Age Group	Nelson County		Griggs County		NGDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0 9	170	50 4%	131	46 5%	301	48 6%	40,200	48.8%
10 19	261	48 9%	210	51 0%	471	49 8%	49,823	48 3%
20-29	89	44 5%	65	40 6%	154	42 8%	42,196	47 3%
30-39	183	48 4%	136	48 1%	319	48 3%	41,884	49 2%
40-49	270	49 3%	218	49 2%	488	49 2%	48,521	49 3%
50 59	214	46 0%	162	46 4%	376	46 2%	32,799	49 0%
60 69	218	49 7%	138	53 6%	356	51 1%	24,937	52 3%
70-79	267	55 9%	167	52 8%	434	54 7%	23,106	55 2%
80+	225	67 0%	154	61 4%	379	64 6%	19,210	65 1%
Total	1897	51 1%	1381	50 1%	3278	50 7%	321,676	50 1%

Nelson and Griggs Community Health Profiles

POPULATION

Race, 2000 Census	Nelson County		Griggs County		NGDHU		North Dakota	
Race	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Total	3715	100 0%	2754	100 0%	6469	100 0%	642,200	100 0%
White	3662	98 6%	2735	99 3%	6397	98 9%	593,181	92 4%
Black	3	0 1%	0	0 0%	3	0 0%	3,910	0 6%
Am Indian	13	0 3%	6	0 2%	19	0 3%	31,329	4 9%
Asian	11	0 3%	4	0 1%	15	0 2%	3,606	0 6%
Pac Islander	0	0 0%	0	0 0%	0	0 0%	230	0 0%
Other	4	0 1%	4	0 1%	8	0 1%	2,540	0 4%
Multirace	22	0 6%	5	0 2%	27	0 4%	7,398	1 2%

Household Populations, 2000 Census	Nelson County		Griggs County		NGDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	3,715	100 0%	2,754	100 0%	6,469	100.0%	642,000	100 0%
In Family Households	2,884	77 6%	2,268	82 4%	5,152	79 6%	507,681	79 1%
In Non-Family Households	671	18 1%	429	15 6%	1,100	17 0%	110,988	17 3%
Total In Households	3,555	95 7%	2,697	97 9%	6,252	96.6%	618,669	96 4%
Institutionalized	146	3 9%	57	2 1%	203	3 1%	9,688	1 5%
Non-Institutionalized	14	0 4%	0	0 0%	14	0 2%	13,943	2 2%
Total in Group Quarters	160	4 3%	57	2.1%	217	3 4%	23,631	3.7%

Population Change 1990 to 2000 Census				
Census	Nelson County	Griggs County	NGDHU	North Dakota
1990	4,410	3,303	7,713	638,800
2000	3,715	2,754	6,469	642,200
Change	-15 8%	-16 6%	-16 1%	0 5%

Marital Status of Persons Age 15 and Older, 2000 Census	Nelson County		Griggs County		NGDH		North Dakota	
Marital Status	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Age 15+	3,098	100 0%	2,280	100.0%	5,378	100 0%	512,281	100 0%
Never Married	579	18 7%	459	20 1%	1,038	19 3%	141,300	27 6%
Now Married	1,811	58 5%	1,469	64 4%	3,280	61.0%	290,833	56 8%
Separated	12	0 4%	12	0 5%	24	0 4%	3,610	0.7%
Widowed	447	14 4%	232	10 2%	679	12 6%	36,702	7 2%
Female	380	12 3%	195	8 6%	575	10 7%	30,346	5 9%
Divorced	249	8 0%	108	4 7%	357	6 6%	39,836	7 8%
Female	119	3 8%	49	2 1%	168	3 1%	21,235	4.1%

Nelson and Griggs Community Health Profiles

POPULATION

Educational Attainment Among Persons 25+, 2000 Census	Nelson County		Griggs County		NGDHU		North Dakota	
Education	Number	Percent	Number	Percent	Number	Percent	Number	Percent
No schooling completed	0	0 0%	9	0 5%	9	0 2%	1605	0 4%
No High School	268	9 7%	245	12 3%	245	5 2%	34053	8 3%
Some High School	245	8 9%	170	8 5%	170	3 6%	30326	7 4%
High school or GRE	849	30 8%	650	32 6%	650	13 7%	113931	27 9%
Some College	910	33 1%	606	30 4%	606	12 8%	138855	34 0%
Bachelor's degree	412	15 0%	256	12 8%	256	5 4%	67551	16 5%
Post Graduate Degree	69	2 5%	57	2 9%	57	1 2%	22292	5 5%

Persons Age 5 and Older with Disability, 2000 Census	Nelson County		Griggs County		NGDHU		North Dakota	
Group	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	3,411	100 0%	2,567	100 0%	5,978	100 0%	586,289	100 0%
No Disability	2,694	79 0%	2,050	79 9%	4,744	79 4%	488,472	83.3%
Any Disability	717	21 0%	517	20 1%	1,234	20 6%	97,817	16 7%
Self Care Disability	60	1.8%	34	1 3%	94	1 6%	11,011	1 9%
5 15 with any disability	31	5 8%	6	1 5%	37	4 0%	5,586	5 6%
16-64 with any disability	347	17 5%	179	11 8%	526	15 0%	58,630	14 7%
65+ with any disability	339	38 0%	232	35.7%	571	37 0%	33,601	38 5%

Income and Poverty Status by Age Group, 2000 Census	Nelson County	Griggs County	NGDHU	North Dakota
Median Household Income	$28,892	$29,572	NA	$34,604
Per Capita Income	$16,320	$16,131	NA	$16,227

	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Below Poverty Level	366	10 3%	272	10 1%	638	10 2%	73,457	11 9%
Under 5 years	14	10.1%	17	13 7%	31	11 8%	6,784	17 6%
5 to 11 years	45	15 9%	18	9 1%	63	13 1%	8,666	14 3%
12 to 17 years	41	10 6%	29	9 8%	70	10 2%	6,713	11 3%
18 to 64 years	174	9 4%	141	9 9%	315	9 6%	41,568	11.1%
65 to 74 years	40	9 0%	24	8 2%	64	8 7%	3,797	8 4%
75 years and over	52	11 6%	43	12 1%	95	11 8%	5,929	14 1%

Nelson and Griggs Community Health Profiles

POPULATION

Family Poverty and Childhood and Elderly Poverty, 2000 Census	Nelson County		Griggs County	
	Number	Percent	Number	Percent
Total Families	1013	100.0%	778	100.0%
Families in Poverty	73	7.2%	61	7.8%
Families with Own Children	412	40.7%	322	41.4%
Families with Own Children in Poverty	38	9.2%	22	6.8%
Families with Own Children and Female Parent Only	66	6.5%	17	2.2%
Families with Own Children and Female Parent Only in Poverty	17	25.8%	4	23.5%
Total Known Children in Poverty	100	12.4%	64	10.3%
Total Known Age 65+ in Poverty	92	10.3%	67	10.3%

Family Poverty and Childhood and Elderly Poverty, 2000 Census	NGDHU		North Dakota	
	Number	Percent	Number	Percent
Total Families	1791	100.0%	166963	100.0%
Families in Poverty	134	7.5%	13890	8.3%
Families with Own Children	734	41.0%	83678	50.1%
Families with Own Children in Poverty	60	8.2%	10043	12.0%
Families with Own Children and Female Parent Only	83	4.6%	13971	8.4%
Families with Own Children and Female Parent Only in Poverty	21	25.3%	5402	38.7%
Total Known Children in Poverty	164	11.5%	22,163	13.8%
Total Known Age 65+ in Poverty	159	10.3%	9,726	10.2%

Age of Housing, 2000 Census	Nelson County		Griggs County		NGDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Housing units Total	2,014	100.0%	1,521	100.0%	3,535	100.0%	289,677	100.0%
1980 and Later	215	10.7%	129	8.5%	344	9.7%	76,239	26.3%
1970 to 1979	397	19.7%	244	16.0%	641	18.1%	68,376	23.6%
Prior to 1970	1,402	69.6%	1,148	75.5%	2,550	72.1%	145,062	50.1%

Nelson and Griggs Community Health Profiles

Vital Statistics Data

BIRTHS AND DEATHS

Births, 2004- 2008	Nelson County		Griggs County		NGDHU		North Dakota	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Live Births and Rate	118	6	101	7	219	7	42925	13
Pregnancies and Rate	140	8	111	8	251	8	47350	15
Fertility Rate		44		50		46		63
Teen Births and Rate	0	0	0	0	0	0	3306	17
Teen Pregnancies and Rate	NA		NA		NA		4097	21
Out of Wedlock Births and Ratio	13	110	16	158	29	132	13743	320
Out of Wedlock Pregnancies and Ratio	33	236	34	306	67	267	16862	356
Low Birth Weight Birth and Ratio	0	0	0	0	0	0	2823	66

Child Deaths, 2004-2008	Nelson County		Griggs County		NGDHU		North Dakota	
	Number	Rate or Ratio	Number	Rate or Ratio	Number	Rate or Ratio	Number	Rate or Ratio
Infant Deaths and Ratio	0	0	0	0	0	0	261	6.1
Child and Adolescent Deaths and Rate	0	0	0	0	0	0	290	33
Total Deaths and Crude Rate	302	0	193	0	0	0	28,494	887

Deaths and Age Adjusted Death Rate by Cause, 2004-2008	Nelson County	Griggs County	NGDHU	North Dakota
	Number (Adj. Rate)	Number (Adj. Rate)	Number (Adj. Rate)	Number (Adj. Rate)
All Causes	302 (759)	193 (689)	495 (731)	28,494 (739)
Heart Disease	86 (190)	57 (173)	142 (182)	7,327 (183)
Cancer	62 (157)	43 (172)	105 (165)	6,573 (180)
Stroke	29 (65)	17 (45)	46 (57)	1,872 (45)
Alzheimers Disease	28 (59)	7 (18)	35 (42)	1,679 (38)
COPD	12 (29)	7 (29)	19 (29)	1,449 (37)
Unintentional Injury	16 (69)	14 (84)	30 (75)	1,477 (42)
Diabetes Mellitus	5 (13)	*	8 (13)	1,059 (26)
Pneumonia and Influenza	11 (24)	*	14 (17)	769 (18)
Cirrhosis	*	0	*	295 (9)
Suicide	*	*	*	433 (13)

Adj Rate = Age Adjusted Rate, *=fewer than 5 deaths

Nelson and Griggs Community Health Profiles

Vital Statistics Data

BIRTHS AND DEATHS

Leading Causes of Death by Age Group for NGDHU, 2004-2008

Age	1	2	3
0-4	Unintentional Injury		
5-14	Unintentional Injury		
15-24	Unintentional Injury	Cancer	
25-34	Unintentional Injury	Suicide	
35-44	Unintentional Injury	Cancer	Suicide
45-54	Cancer	Heart	Unintentional Injury
55-64	Cancer 10	Heart 6	Unintentional Injury
65-74	Cancer 25	Heart 19	[illegible]
75-84	Cancer 32	Heart 32	Stroke 20
85+	Heart 82	Cancer 32	Stroke 23

Nelson and Griggs Community Health Profiles

ADULT BEHAVIORAL RISK FACTORS, 1999-2007

		Nelson County	Griggs County	NGDHU	North Dakota
ALCOHOL					
Binge Drinking	Respondents who reported binge drinking (5 drinks for men, 4 drinks for women) one or more times in the past 30 days.	23.9 (16.4-31.5)	13.7 (7.2-20.2)	19.8 (14.5-25.2)	21.6 (19.9-23.3)
Heavy Drinking	Respondents who reported heavy drinking (more than 2 drinks per day for men, more than 1 drink per day for women) during the past 30 days	7.0 (2.0-12.0)	3.0 (0.0-6.6)	5.6 (2.1-9.0)	5.1 (4.1-6.1)
Drunk Driving	Respondents who reported driving when they had too much to drink one or more times during the past 30 days	4.5 (0.0-9.7)	7.1 (0.0 15.3)	5.6 (1.0 10.2)	4.6 (3.6-5.5)
ARTHRITIS					
Chronic Joint Symptoms	Respondents who reported pain, aching of stiff in a joint during the past 30 days which started more than 3 months ago	NA	NA	36.8 (28.7-45.0)	31.7 (30.1-33.4)
Activity Limitation Due to Arthritis	Respondents who reported being limited in any usual activities because of arthritis or joint symptoms.	NA	NA	13.8 (8.5-19.1)	10.7 (9.8-11.7)
Doctor Diagnosed Arthritis	Respondents who reported ever have been told by a doctor or other health professional that they had some form of arthritis	NA	NA	40.2 (32.1-48.4)	26.9 (25.4-28.4)
ASTHMA					
Ever Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma	12.3 (6.0-18.7)	7.2 (2.2-12.3)	10.5 (6.0-15.0)	11.6 (10.4-12.8)
Current Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma and who still have asthma	4.7 (1.4-7.9)	3.7 (0.6-6.8)	4.3 (1.9-6.7)	7.9 (6.9-9.0)
BODY WEIGHT					
Overweight But Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight)	41.8 (34.1-49.6)	47.7 (38.1-57.2)	44.1 (38.1-50.2)	39.6 (37.7-41.5)
Obese	Respondents with a body mass index greater than or equal to 30 (obese)	30.2 (22.8-37.6)	20.3 (13.0-27.6)	26.3 (20.9-31.7)	27.8 (26.1-29.5)
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese)	72.0 (65.0-79.1)	68.0 (59.2-76.8)	70.5 (65.0-76.0)	67.4 (65.5 69.3)

Nelson and Griggs Community Health Profiles

ADULT BEHAVIORAL RISK FACTORS, 1999-2007

CARDIOVASCULAR		Nelson County	Griggs County	NGDHU	North Dakota
Heart Attack	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a heart attack	8 3 (3 8-12 8)	8 1 (2 4-13 8)	8 2 (4 7-11 7)	3 9 (3 4- 4 5)
Angina	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had angina	6 2 (2 1-10 3)	6 3 (1 4-11 2)	6 2 (3 1- 9 4)	4 1 (3 5- 4 6)
Stroke	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a stroke	3 5 (0 7- 6 2)	1 0 (0 0- 2 9)	2 5 (0 6- 4 3)	2 3 (1 9- 2 7)
Cardiovascular Disease	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had any of the following: heart attack, angina or stroke	11 8 (6 6-17 0)	11 1 (4 9-17 4)	11 5 (7 5-15 5)	7 5 (6 8- 8.3)
CHOLESTEROL					
Never Cholesterol Test	Respondents who reported never having a cholesterol test	15.6 (9 2-22 0)	22 7 (13 0 32 5)	18 5 (12 9-24 0)	22 5 (20 6-24 5)
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years	19 4 (12 4-26 5)	25 8 (15 7-35 9)	22 0 (16 1-27.9)	27 3 (25 3-29 3)
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol	36 4 (26 7-46 1)	43 9 (29 5-58 2)	39 0 (30 9-47 1)	37 1 (35 3-38 9)
COLORECTAL CANCER					
Fecal Occult Blood	Respondents age 50 and older who reported not having a fecal occult blood test in the past two years	NA	NA	64 9 (51.6-78 1)	77 8 (76 1-79.4)
Never Sigmoidoscopy	Respondents age 50 and older who reported never having had a sigmoidoscopy or colonoscopy	NA	NA	45 0 (30 3-59 6)	42 1 (40 2-44 0)
No Sigmoidoscopy in Past 5 Years	Respondents age 50 and older who reported not having a sigmoidoscopy or colonoscopy in the past five years	NA	NA	51 2 (39 7-62 8)	62 1 (60 2-64 0)
DIABETES					
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes	8 9 (4.1-13 8)	2 5 (0 0- 6 1)	6 6 (3 3-10 0)	7 6 (6 8- 8.4)
FRUITS AND VEGETABLES					
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day	69 8 (60 6-79 0)	85 2 (76 9-93 6)	75 8 (69 1-82 4)	78.1 (76 5-79 6)

Nelson and Griggs Community Health Profiles

ADULT BEHAVIORAL RISK FACTORS, 1999-2007

	GENERAL HEALTH	Nelson County	Griggs County	NGDHU	North Dakota
Fair or Poor Health	Respondents who reported that their general health was fair or poor	14.9 (9.8-19.9)	15.6 (9.1-22.2)	15.2 (11.2-19.2)	13.4 (12.2-14.6)
Poor physical Health	Respondents who reported they had 8 or more days in the last 30 when their physical health was not good	9.7 (5.3-14.2)	13.8 (6.8-20.8)	11.3 (7.4-15.2)	10.6 (9.6-11.6)
Poor Mental Health	Respondents who reported they had 8 or more days in the last 30 when their mental health was not good	9.4 (4.7-14.1	5.4 (1.0 9.9)	7.8 (4.5-11.2)	8.9 (7.8-10.0)
Activity Limitation Due to Poor Health	Respondents who reported they had 8 or more days in the last 30 when poor physical or mental health kept them from doing their usual activities	7.2 (3.3-11.1)	9.0 (2.6-15.5)	7.9 (4.5-11.4)	5.4 (4.7- 6.2)
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem	18.1 (12.5-23.8)	15.8 (9.0-22.5)	17.2 (12.9-21.6)	17.0 (15.8-18.3)
	HEALTH CARE ACCESS				
Health Insurance	Respondents who reported not having any form or health care coverage	12.9 (7.6-18.2)	14.9 (8.2-21.5)	13.7 (9.5-17.8)	11.6 (10.1-13.2)
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost	7.2 (3.0-11.3)	7.6 (1.7-13.5)	7.3 (3.9-10.7)	6.2 (5.3- 7.1)
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider	18.1 (11.3-25.0)	27.7 (18.1-37.3)	21.7 (16.0 27.3)	23.8 (22.0-25.6)
	HYPERTENSION				
High Blood Pressure	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had high blood pressure	41.7 (30.6-52.8)	34.0 (21.8-46.1)	38.8 (30.4-47.2)	26.0 (24.5-27.4)
	IMMUNIZATION				
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year	29.2 (17.9-40.4)	24.5 (10.9-38.1)	27.3 (18.7-36.0)	26.5 (24.1-28.8)
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	31.8 (20.0-43.6)	32.3 (15.8-48.9)	32.0 (22.2-41.8)	31.6 (29.0-34.2)
	INJURY				
Fall	Respondents 45 years and older who reported that they had fallen in the past 3 months	NA	NA	8.8 (0.0-18.0)	13.9 (12.7-15.2)
	ORAL HEALTH				
Dental Visit	Respondents who reported that they have not had a dental visit in the past year	NA	NA	38.1 (28.3 47.9)	25.9 (24.3-27.6)
Tooth Loss	Respondents who reported they had lost 6 or more permanent teeth due to gum disease or decay	NA	NA	28.5 (19.4-37.7)	14.9 (13.8-15.9)

Nelson and Griggs Community Health Profiles

ADULT BEHAVIORAL RISK FACTORS, 1999-2007

	PHYSICAL ACTIVITY	Nelson County	Griggs County	NGDHU	North Dakota
Recommend Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity	NA	NA	40 4 (32 3-48 6)	37 4 (35 5-30 3)
No Leisure Physical Activity	Respondents who reported that they participated in no leisure time physical activity	13 0 (5 5-20 6)	7 5 (0 8-14 3)	11 1 (5 6-16.5)	6 0 (5 2- 6 9)
	TOBACCO				
Current Smoking	Respondents who reported that they smoked every day or some days	19.5 (13 6-25 4)	15 6 (8 9-22 4)	18 0 (13 5-22.4)	18 1 (16 5-19 7)
	PROSTATE CANCER				
PSA Testing	Men age 40 and older who reported that they have not had a PSA test in the past two years	NA	NA	NA	45 4 (42.7-48 2)
	WOMEN'S HEALTH				
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years	NA	NA	16 9 (8 3-25 5)	17 2 (14 7-19 9)
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years	NA	NA	10.5 (3 9-17.1)	23 1 (21 2-25 1)

Nelson and Griggs Community Health Profiles

CRIME

Nelson County

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	NA	0	0	0	0	0	0 0
Rape	NA	0	0	0	0	0	0 0
Robbery	NA	0	0	0	0	0	0 0
Assualt	NA		1	3	2	6	43 9
Violent crime	0	0	1	3	2	6	43 9
Burglary	NA	0	2	10	4	16	117 0
Larceny	NA	4	26	9	1	40	292 4
Motor vehicle theft	NA	0	4	7	7	18	131 6
Property crime	0	4	32	26	12	74	540 9
Total	0	4	33	29	14	80	584 8

Griggs County

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	0	0	0	0	0	0	0 0
Rape	0	0	1	0	0	1	8.0
Robbery	0	0	0	0	0	0	0 0
Assualt	0	0	0	0	0	0	0 0
Violent crime	0	0	1	0	0	1	8 0
Burglary	0	1	1	2	0	4	32 1
Larceny	0	2	1	3	0	6	48 1
Motor vehicle theft	1	0	0	0	0	1	8 0
Property crime	1	3	2	5	0	11	88 2
Total	1	3	3	5	0	12	96 2

North Dakota

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	10	13	8	16	4	51	1.6
Rape	157	146	184	202	222	911	28 4
Robbery	42	45	69	68	71	295	9 2
Assualt	319	396	525	599	738	2,577	80 3
Violent crime	528	600	766	885	1,035	3,834	119 5
Burglary	1,855	1,884	2,364	2,096	2,035	10,234	319 1
Larceny	8,832	9,081	8,884	8,672	8,926	44,395	1384.1
Motor vehicle theft	858	998	966	878	854	4,554	142 0
Property crime	11,545	11,963	12,214	11,646	11,815	59,183	1845 1
Total	12,073	12,563	13,000	12,531	12,850	63,017	1964.7

Nelson and Griggs Community Health Profiles

CHILD HEALTH INDICATORS

Child Indicators: Education 2008	Nelson County	Griggs County	North Dakota
Children Ages 3 and 4 Enrolled in Head Start (Percent of all children Head Start eligible)	15 (71)	4 (67)	2,607(65)
Enrolled in Special Education Ages 3-21 (Number and percent of total school enrollment)	92 (20)	61 (16)	13,278(14)
Speech or Language Impaired Children in Special Education (Percent of all special education children)	33 (36)	7 (12)	3,644 (27)
Mentally Handicapped Children in Special Education (Percentage of total special education children)	4 (4)	1 (1 6)	860 (6 5)
Children with Specific Learning Disability in Special Education (Percentage of total special education children)	30 (33)	27 (44)	4,224 (32)
High School Dropouts (Dropouts per 1000 persons Grades 9-12)	0	1 (0 7)	791 (2 4)
Average ACT Composite Score	20 7	22 1	21 5
Average Expenditure per Student in Public School	$8,217	$9,309	$8,096

Child Indicators: Economic Health 2008	Nelson County	Griggs County	North Dakota
TANF Recipients Ages 0-19 (Percent of persons ages 0-19)	4 (0 7)	15 (3 3)	7,532 (4 5)
Food Stamp Recipients Ages 0-19 (Percent of all children ages 0-19)	98 (17)	72 (16)	31,380 (20)
Children Receiving Free and Reduced Price Lunches (Percent of total school enrollment	190 (40)	167 (43)	32,445 (32)
Medicaid Recipients Ages 0-20 (Percent of all persons ages 0-20)	132 (19)	117 (22)	41,376 (23)
Median Income for Families with Children Ages 0-17 (Percent of all women with children ages 0-17)*	$40,729	$41,458	$44,640
Children Ages 0-17 Living in Extreme Poverty (Percent of children 0-17 for whom poverty is determined)*	57 (7 1)	22 (3 6)	11,000 (8)
* Year 2000 data			

Child Indicators: Families and Child Care 2008	Nelson County	Griggs County	North Dakota
Child Care Providers - All Approved Categories	10	7	3,353
Child Care Capacity	106	132	43,213
Mothers in Labor Force with a Child Ages 0-17 (Percent of all mothers with a child ages 0-17)*	320 (83)	264 (89)	63,085 (81)
Children Ages 0-17 Living in a Single Parent Family (Percent of all children ages 0-17)*	104 (13)	58 (9 3)	30,695 (18)
Children in Foster Care (Percent of children ages 0-18)	2 (0 4)	2 (0 8)	2,134 (1 4)
Children Ages 0-17 with Suspected Child Abuse or Neglect (Cases per 100 children 0-17)	7 (1 4)	12 (2 9)	6,982 (4 9)
Children Ages 0 17 Impact by Domestic Violence (Percent of all children ages 0-17)	11 (1 3)	2 (0 3)	4,862 (3 0)
Births to Mothers with Inadequate Prenatal Care**	NA	0	478 (5 4)
** 2007 data ***2002 data			

Child Indicators: Juvenile Justice 2008	Nelson County	Griggs County	North Dakota
Children Ages 10-17 Referred to Juvenile Court (Percent of all children ages 0-17)	12 (4 5)	8 (3 5)	5,655 (8 4)
Offense Against Person Juvenile Court Referral (Percent of total juvenile court referral)	1 (4 2)	0	808 (7 8)
Alcohol-Related Juvenile Court Referral (Percent of all juvenile court referrals)	2 (8 3)	5 (56)	1,845 (18)

Steele County Community Health Profile

POPULATION

The Demographic Section of this report comes from the US Census Bureau (www.census.gov) Most tables are derived either from the full (100%) census taken in 2010 or from the Community Population Survey aggregrated over a several year period The table header describes the specific years from which the data is derived The table showing percent population change uses census data from 2000 also Tables present number of persons and percentages which in almost all circumstances represent the category specific percentage of all persons referenced by the table (e g , percentage of persons age 15 and older who are married). Age specific poverty rates represent the percentage of each age group which is in poverty (e g , percentage of children under five years in poverty)

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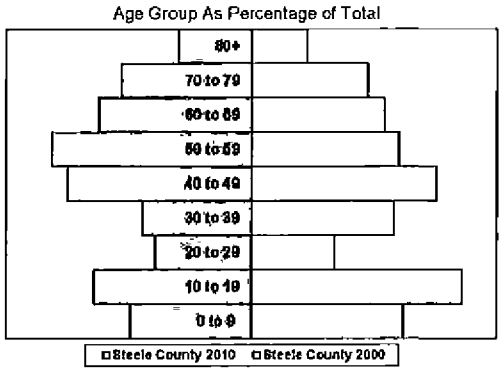
Population by Age Group, 2010 Census

Age Group	Steele County		North Dakota	
	Number	Percent	Number	Percent
0-9	195	9 9%	84,671	12 6%
10-19	255	12 9%	87,264	13 0%
20-29	157	7 9%	108,552	16 1%
30-39	176	8 9%	77,954	11 6%
40-49	296	15 0%	84,577	12 6%
50-59	322	16 3%	96,223	14 3%
60-69	246	12 5%	61,901	9 2%
70-79	209	10 6%	39,213	5.8%
80+	119	6 0%	32,236	4 8%
Total	1,975	100.0%	672,591	100 0%
0-17	421	21 3%	149,871	22 3%
65+	441	22 3%	97,477	14 5%



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Female Population and Percentage Female by Age, 2010 Census

Age Group	Steele County		North Dakota	
	Number	Percent	Number	Percent
0-9	104	53 3%	41,330	48 8%
10-19	137	53 7%	42,277	48 4%
20-29	69	43 9%	50,571	46 6%
30-39	83	47 2%	37,144	47 6%
40-49	141	47 6%	41,499	49 1%
50-59	145	45 0%	47,263	49 1%
60-69	108	43 9%	30,699	49 6%
70-79	114	54 5%	21,453	54 7%
80+	65	54 6%	20,471	63 5%
Total	966	48 9%	332,727	49 5%
0-17	223	53 0%	73,083	48 8%
65+	234	53 1%	55,050	56 5%

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Decennial Population Change, 1990 to 2000, 2000 to 2010

Census	Steele County	10 Year Change	North Dakota	10 Year Change
1990	2,420	(%)	638,800	(%)
2000	2,258	-6 7%	642,200	0.5%
2010	1,975	-12 5%	672,591	4.7%

Steele County Community Health Profile

POPULATION

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Race, 2010 Census	Steele County		North Dakota	
Race	Number	Percentage	Number	Percentage
Total	1,975	100.0%	672,591	100 0%
White	1,927	97.6%	605,449	90 0%
Black	3	0 2%	7,960	1 2%
Am Indian	23	1 2%	36,591	5 4%
Asian	2	0 1%	6,909	1 0%
Pac Islander	0	0.0%	320	0 0%
Other	8	0 4%	3,509	0 5%
Multirace	12	0 6%	11,853	1 8%

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Household Populations, 2010	Steele County		North Dakota	
Household Type	Number	Percentage	Number	Percentage
Total	1,977	100 0%	659,858	100 0%
In households	1,977	100.0%	634,679	96 2%
In family households:	1,703	86.1%	504,148	76 4%
In nonfamily households	274	13.9%	130,531	19 8%
In group quarters	0	0 0%	25,179	3 8%
Institutionalized population	0	0 0%	9,675	1 5%
Noninstitutionalized population	0	0 0%	15,504	2 3%

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Marital Status of Persons Age 15 and Older, 2006-2010 ACS	Steele County		North Dakota	
Marital Status	Number	Percent	Number	Percent
Total Age 15+	1,616	100 0%	538,799	100 0%
Never Married	323	20 0%	163,256	30 3%
Now Married	1,025	63 4%	288,257	53 5%
Separated	10	0 6%	4,310	0 8%
Widowed	131	8 1%	36,100	6 7%
Divorced	128	7 9%	46,876	8 7%

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Educattional Attainment, 2006-2010, ACS	Steele County		North Dakota	
	Estimate	Percent	Estimate	Percent
Population 25 years and over	1,394	100.0%	429,333	100 0%
Less than 9th grade	91	6 5%	24,043	5 6%
9th to 12th grade, no diploma	67	4.8%	21,467	5 0%
High school graduate or GED	431	30 9%	120,643	28 1%
Some college, no degree	390	28 0%	99,176	23.1%
Associate's degree	158	11 3%	51,091	11 9%
Bachelor's degree	206	14 8%	83,291	19 4%
Grad degree or prof degree	49	3.5%	29,624	6 9%

Steele County Community Health Profile

POPULATION

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Income and Poverty Status by Age Group, 2006-2010, ACS				
	Steele County		North Dakota	
Median Household Income	$44,191		$46,781	
Per Capita Income	$27,728		$25,803	
	Number	Percent	Number	Percent
Below Poverty Level	83	4 2%	78,405	12 3%
Under 5 years	8	7 9%	4,120	9 2%
5 to 11 years	15	10 7%	7,908	14 2%
12 to 17 years	9	5 0%	5,457	11 0%
18 to 64 years	29	2 6%	46,471	12 0%
65 to 74 years	2	0 9%	4,149	8 9%
75 years and over	20	8 9%	7,072	14 0%
Total Known Children in Poverty (0-17)	32	7 6%	17,485	11 7%
Total Known Age 65+ in Poverty	22	5 0%	11,221	11 5%

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Family Poverty and Childhood and Elderly Poverty, 2006-2010, ACS				
	Steele County		North Dakota	
	Number	Percent	Number	Percent
Total Families	578		170,477	100.0%
Families in Poverty	25		12,274	7 2%
Families with Related Children	204		78,224	45 9%
Families with Related Children in Poverty	14		10,679	6 3%
Families with Related Children and Female Parent Only	64		15,482	9 1%
Families with Related Children and Female Parent Only in Poverty	14		6,022	3 5%

Steele County Community Health Profile

Vital Statistics Data

BIRTHS AND DEATHS

Vital Statistics Data comes from the birth and death records collected by the State of North Dakota aggregated over a five year period All births and deaths represent the county of residence not the county of occurrence The number of events is blocked if fewer than six Formulas for calculating rates and ratios are as follows

Birth Rate = Resident live births divided by the total resident population x 1000
Pregnancies = Live births + Fetal deaths + Induced termination of pregnancy.
Pregnancy Rate = Total pregnancies divided b the total resident population x 1000
Fertility Rate = Resident live births divided by female population (age 15-44) x 1000
Teenage Birth Rate = Teenage births (age <20) divided by female teen population x 1000.
Teenage Pregnancy Rate = Teenage pregnancies (age<20) divided by female teen population x 1000
Out of Wedlock Live Birth Ratio = Resident OOW live births divided by total resident live births x 1000
Out of Wedlock Pregnancy Ratio = Resident OOW pregnancies divided by total pregnancies x 1000
Low Weight Ratio = Low weight births (birth weight < 2500 grams) divided by total resident live births x 1000
Infant Death Ratio = Number of infant deaths divided by the total resident live births x 1000.
Childhood & Adolescent Deaths = Deaths to individuals 1 - 19 years of age.
Childhood and Adolescent Death Rate = Number of resident deaths (age 1 - 19) divided by population (age 1 - 19) x 100,000
Crude Death Rate = Death events divided by population x 100,000
Age-Adjusted Death Rate = Death events with age specific adjustments x 100,000 population

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Births, 2006-2010	Steele County		North Dakota	
	Number	Rate	Number	Rate
Live Births	89	9	44,427	13
Pregnancies	92	9	48,818	15
Fertility Ratio		70		71
Teen Births	0	0	3,337	19
Teen Pregnancies	0	0	4,062	23
	Number	Ratio	Number	Ratio
Out of Wedlock Births	7	79	14,506	327
Out of Wedlock Pregnancies	14	152	18,103	371
Low Birth Weight Births	0	0	2,919	66

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Deaths, 2006-2010	Steele County		North Dakota	
	Number	Ratio	Number	Ratio
Infant Deaths	0	0	281	6
	Number	Rate	Number	Rate
Child and Adolescent Deaths	<6	NR	285	35
Total Deaths	76	770	28,984	862

Steele County Community Health Profile

Vital Statistics Data

BIRTHS AND DEATHS

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Deaths and Age Adjusted Death Rate by Cause, 2006-2010	Steele County Number (Adj. Rate)	North Dakota Number (Adj. Rate)
All Causes	76 (478)	28,985 (689)
Heart Disease	22 (122)	7,122 (162)
Cancer	20 (122)	6,544 (162)
Stroke	6 (31)	1,696 (38)
Alzheimers Disease	0	1,936 (40)
COPD	<6	1,607 (39)
Unintentional Injury	<6	1,545 (42)
Diabetes Mellitus	<6	1,072 (26)
Pneumonia and Influenza	<6	702 (15)
Cirrhosis	<6	289 (8)
Suicide	<6	462 (14)

Steele County Community Health Profile

Vital Statistics Data

BIRTHS AND DEATHS

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Leading Causes of Death by Age, Steele County, 2004-2008

Age	1	2	3
0-4			
5-14	Cancer		
15-24	Unintentional Injury		
25-34	Unintentional Injury		
35-44	Suicide		
45-54	Heart	Cancer	
55-64	Cancer	Heart	Unintentional Injury
65-74	Cancer	Heart	Diabetes
75-84	Cancer	COPD	Stroke
		Heart	Unintentional Injury
85+	Heart 13	Stroke	Cancer

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Leading Causes of Death by Age Group for North Dakota, 2006-2010

Age	1	2	3
0-4	Congenital Anomaly 69	Prematurity 44	SIDS 40
5-14	Unintentional Injury 26	Cancer 10	Congenital Anomaly 6
15-24	Unintentional Injury 184	Suicide 109	Cancer 20
25-34	Unintentional Injury 166	Suicide 91	Heart 32
35-44	Unintentional Injury 175	Heart 94	Cancer 88
45-54	Cancer 493	Heart 335	Unintentional Injury 194
55-64	Cancer 1001	Heart 579	Unintentional Injury 137
65-74	Cancer 1562	Heart 843	(illegible)
75-84	Cancer 1992	Heart 1797	(illegible)
85+	Heart 3421	Alzheimer's Dz 1391	Cancer 1352

Steele County Community Health Profile

ADULT BEHAVIORAL RISK FACTORS, 2001-2010

Adult Behavioral Risk Factor data are derived from aggregated data (the number of years specified is in the table) continuously collected by telephone survey from persons 18 years and older. All data is self-reported data. Numbers given are point estimate percentages followed by 95% confidence intervals. Statistical significance can be determined by comparing confidence intervals between two geographic areas. To be statistically significant, confidence may not overlap. For example the confidence intervals 9.3 (8.3-10.2) and 10.8 (10.0-11.6) overlap (see picture below) so the difference between the two numbers is not statistically significant. That means that substantial uncertainty remains whether the apparent difference is due to chance alone (due to sampling variation) rather than representing a true difference in the prevalence of the condition in the two populations. The less they overlap, the more likely it is that the point estimates represent truly different prevalences in the two populations.

	ALCOHOL	Steele County %	North Dakota %
Binge Drinking	Respondents who reported binge drinking (5 drinks for men, 4 drinks for women) one or more times in the past 30 days.	24.0 (14.8-33.2)	21.1 (20.5-21.6)
Heavy Drinking	Respondents who reported heavy drinking (more than 2 drinks per day for men, more than 1 drink per day for women) during the past 30 days	3.3 (0.2-6.5)	5.0 (4.7-5.3)
Drunk Driving	Respondents who reported driving when they had too much to drink one or more times during the past 30 days	4.1 (0.0-8.4)	6.7 (5.1-8.2)
	ARTHRITIS		
Chronic Joint Symptoms	Respondents who reported pain, aching of stiff in a joint during the past 30 days which started more than 3 months ago	NA	35.3 (34.4-36.2)
Activity Limitation Due to Arthritis	Respondents who reported being limited in any usual activities because of arthritis or joint symptoms.	12.7 (4.8-20.6)	13.0 (12.4-13.6)
Doctor Diagnosed Arthritis	Respondents who reported ever have been told by a doctor or other health professional that they had some form or arthritis	NA	27.2 (26.5-27.9)
	ASTHMA		
Ever Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma.	6.7 (1.8-11.6)	10.7 (10.3-11.1)
Current Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma and who still have asthma	3.8 (0.3-7.3)	7.6 (7.2-7.9)

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Steele County Community Health Profile

ADULT BEHAVIORAL RISK FACTORS, 2001-2010

BODY WEIGHT		Steele County %	North Dakota %
Overweight But Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight)	39 0 (30 0-48 0)	38 7 (38 0-39 3)
Obese	Respondents with a body mass index greater than or equal to 30 (obese)	33 8 (24 1-43.5)	25.4 (24 9-26 0)
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese)	72 8 (64 7-80.9)	64 1 (63 5-64.8)
CARDIOVASCULAR			
Heart Attack	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a heart attack	4 6 (0 6- 8 7)	4 0 (3 8- 4 2)
Angina	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had angina	8.9 (3 4-14 4)	4 0 (3 8- 4 3)
Stroke	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a stroke	2 6 (0 0- 5 2)	2 2 (2 1- 2 4)
Cardiovascular Disease	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had any of the following heart attack, angina or stroke.	12 6 (6.4-18.9)	7.4 (7.1- 7.7)
CHOLESTEROL			
Never Cholesterol Test	Respondents who reported never having a cholesterol test	NA	23 0 (22 2-23.8)
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years	NA	28 2 (27 4-29.0)
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol	NA	34.0 (33 2-34 8)
COLORECTAL CANCER			
Fecal Occult Blood	Respondents age 50 and older who reported not having a fecal occult blood test in the past two years	NA	78.3 (77 6-79 2)
Never Sigmoidoscopy	Respondents age 50 and older who reported never having had a sigmoidoscopy or colonoscopy	NA	42 6 (41.4-43 7)
No Sigmoidoscopy in Past 5 Years	Respondents age 50 and older who reported not having a sigmoidoscopy or colonoscopy in the past five years	NA	55 0 (54 0-56 1)
DIABETES			
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes.	5 9 (1 9- 9 8)	6 9 (6 6- 7.2)
FRUITS AND VEGETABLES			
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day	NA	78 4 (77 7-79 1)

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Steele County Community Health Profile

ADULT BEHAVIORAL RISK FACTORS, 2001-2010

GENERAL HEALTH		Steele County %	North Dakota %
Fair or Poor Health	Respondents who reported that their general health was fair or poor	13 3 (7 5-19 0)	12 6 (12 2-12 9)
Poor physical Health	Respondents who reported they had 8 or more days in the last 30 when their physical health was not good	12 8 (6 3-19 4)	10 2 (9 8-10 5)
Poor Mental Health	Respondents who reported they had 8 or more days in the last 30 when their mental health was not good	9.4 (4.4-14 4)	9 6 (9 2-10 0)
Activity Limitation Due to Poor Health	Respondents who reported they had 8 or more days in the last 30 when poor physical or mental health kept them from doing their usual activities	3.4 (0 6- 6 3)	5 7 (5.4- 6.0)
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem	19 6 (12 5-26 8)	16 0 (15 6-16 5)
HEALTH CARE ACCESS			
Health Insurance	Respondents who reported not having any form or health care coverage	10 5 (4.6-16.3)	11 4 (11 0-11 9)
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost	3 9 (0 0- 8 4)	6 8 (6 4- 7 1)
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider.	25.0 (15 5-34 5)	23 5 (23 0-24 1)
HYPERTENSION			
High Blood Pressure	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had high blood pressure	NA	25 0 (24 4-25.7)
IMMUNIZATION			
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year	NA	28 6 (27 6-29 6)
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	NA	30 0 (28 9-31.0)
INJURY			
Fall	Respondents 45 years and older who reported that they had fallen in the past 3 months	NA	15.5 (14 7-16 2)
Seat Belt	Respondents who reported not always wearing their seatbelt	NA	41 9 (40 9-42 9)

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Steele County Community Health Profile

ADULT BEHAVIORAL RISK FACTORS, 2001-2010

	ORAL HEALTH	Steele County %	North Dakota %
Dental Visit	Respondents who reported that they have not had a dental visit in the past year	NA	29.5 (28.8-30.3)
Tooth Loss	Respondents who reported they had lost 6 or more permanent teeth due to gum disease or decay	NA	16.0 (15.5-16.6)
	PHYSICAL ACTIVITY		
Recommend Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity	NA	50.5 (49.7-51.4)
No Leisure Physical Activity	Respondents who reported that they participated in no leisure time physical activity	9.7 (2.1-17.4)	6.9 (6.5-7.4)
	TOBACCO		
Current Smoking	Respondents who reported that they smoked every day or some days	19.3 (12.4-26.3)	19.8 (19.3-20.4)
	WOMEN'S HEALTH		
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years	NA	14.0 (13.1-15.0)
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years	NA	24.3 (23.3-25.3)

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Steele County Community Health Profile

CRIME

Steele County

	2006	2007	2008	2009	2010	5 year	1-Year Rate
Murder	NA	NA	NA	NA	0	NA	0 0
Rape	NA	NA	NA	NA	0	NA	0 0
Robbery	NA	NA	NA	NA	0	NA	0 0
Aggrevated Assualt	NA	NA	NA	NA	1	NA	11.3
Violent crime	NA	NA	NA	NA	1	NA	11
Burglary	NA	NA	NA	NA	0	NA	0 0
Larceny	NA	NA	NA	NA	1	NA	11 3
Motor vehicle theft	NA	NA	NA	NA	0	NA	0 0
Property crime	NA	NA	NA	NA	1	NA	11
Total	NA	NA	NA	NA	2	NA	23

North Dakota

	2006	2007	2008	2009	2010	5 year	5-Year Rate
Murder	8	16	4	15	11	54	1 7
Rape	184	202	222	206	222	1,036	32 3
Robbery	69	68	71	102	85	395	12 3
Aggrevated Assualt	525	599	738	795	847	3,504	109 2
Violent crime	786	885	1,035	1,118	1,165	4,989	155 5
Burglary	2,364	2,096	2,035	2,180	1,826	10,501	327 4
Larceny	8,884	8,672	8,926	8,699	8,673	43,854	1367.2
Motor vehicle theft	966	878	854	825	763	4,286	133 6
Property crime	12,214	11,646	11,815	11,704	11,262	58,641	1828 2
Total	13,000	12,531	12,850	12,822	12,427	63,630	1983 8

Steele County Community Health Profile

CHILD HEALTH INDICATORS

Child Health Indicators are selected from Kid's Count data reported on the web The descriptive line tells what the number present and the part of the description in parentheses tells what the number in parentheses means If the year of the data is different than other data in the table, the year is footnoted

Children Ages 3 to 4 Not Enrolled in School (2010)	Steele County	Minnesota
Children Ages 3 to 4 in Head Start (Percent of eligible 3 to 4 year olds)*	1 (100)	2,607 (65)
Enrolled in Special Education Ages 3-21 (Percent of persons ages 3-21)	29 (12)	13,170 (14)
High School Dropouts (Dropouts per 1000 persons ages 16-24)	1 (0 7)	701 (2 2)
Average ACT Composite Score	19 9	21 5
Average Expenditure per Student in Public School	$10,433	$9,812
*Year 2008 data		

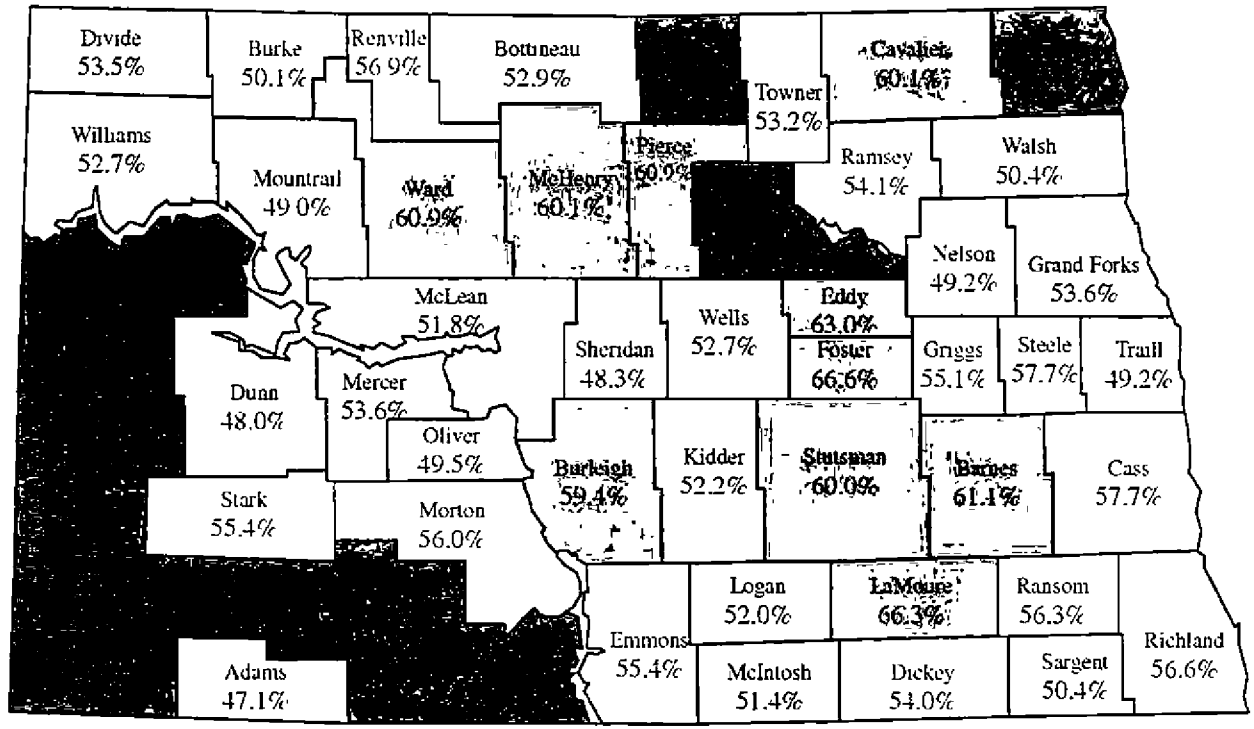
Children Ages 0-19 Receiving Public Aid (2010)	Steele County	Minnesota
TANF Recipients Ages 0-19 (Percent of persons ages 0-19)	5 (1 2)	7,819 (4 7)
SNAP Recipients Ages 0-19 (Percent of all children ages 0-19)	68 (17)	37,553 (24)
Children Receiving Free and Reduced Price Lunches (Percent of total school enrollment	56 *23)	33,870 (33)
WIC Program Participants	43	24,331
Medicaid Recipients Ages 0-20 (Percent of all persons ages 0-20)	98 (22)	49,110 (27)
Median Income for Families with Children Ages 0-17 *	$60,000	$61,035
Children Ages 0-17 Living in Extreme Poverty (Percent of children 0-17 for whom poverty is determined)*	3 (0 7)	10,100 (7 2)
*Year 2009 data		

Children Ages 0-17 Families and Childcare (2010)	Steele County	Minnesota
Child Care Providers	2	3,176
Child Care Capacity (Percent of children 0-13)	31 (12)	41478 (38)
Mothers with a Child Ages 0-17 in Labor Force (Percent of all mothers with a child ages 0-17)*	167 (74)	57,059 (82)
Children Ages 0-17 Living in a Single Parent Family (Percent of all children ages 0-17)*	64 (14)	30,058 (21)
Children in Foster Care (Percent of children ages 0-18)	3 (0 8)	1,912 (1 2)
Children Ages 0-17 with Suspected Child Abuse or Neglect (Cases per 100 children 0-17)	6 (1 6)	6,399 (4 4)
Children Ages 0-17 Impact by Domestic Violence (Percent of all children ages 0-17)	NA	4,180 (2 9)
Births to Mothers with Inadequate Prenatal Care**	0	389 (4 3)
* Year 2009 data		

Children Ages 0-17 Juvenile Justice (2010)	Steele County	Minnesota
Children Ages 0-17 Referred to Juvenile Court (Percent of all children ages 0-17)	12 (5 6)	5,139 (8 1)
Offense Against Person Juvenile Court Referral (Percent of total juvenile court referral)	2 (14)	784 (8 2)
Alcohol-Related Juvenile Court Referral (Percent of all juvenile court referrals)	10 (71)	1,464 (15)

North Dakota Colorectal Cancer Screening Rates

Medicare Claims Data Measurement Timeframes: Numerator—06/01/09-06/30/10
Denominator—FOBT: 06/01/08-06/30/10; BE and SIG: 06/01/05-06/30/10: COLO: 06/01/00-06/30/10

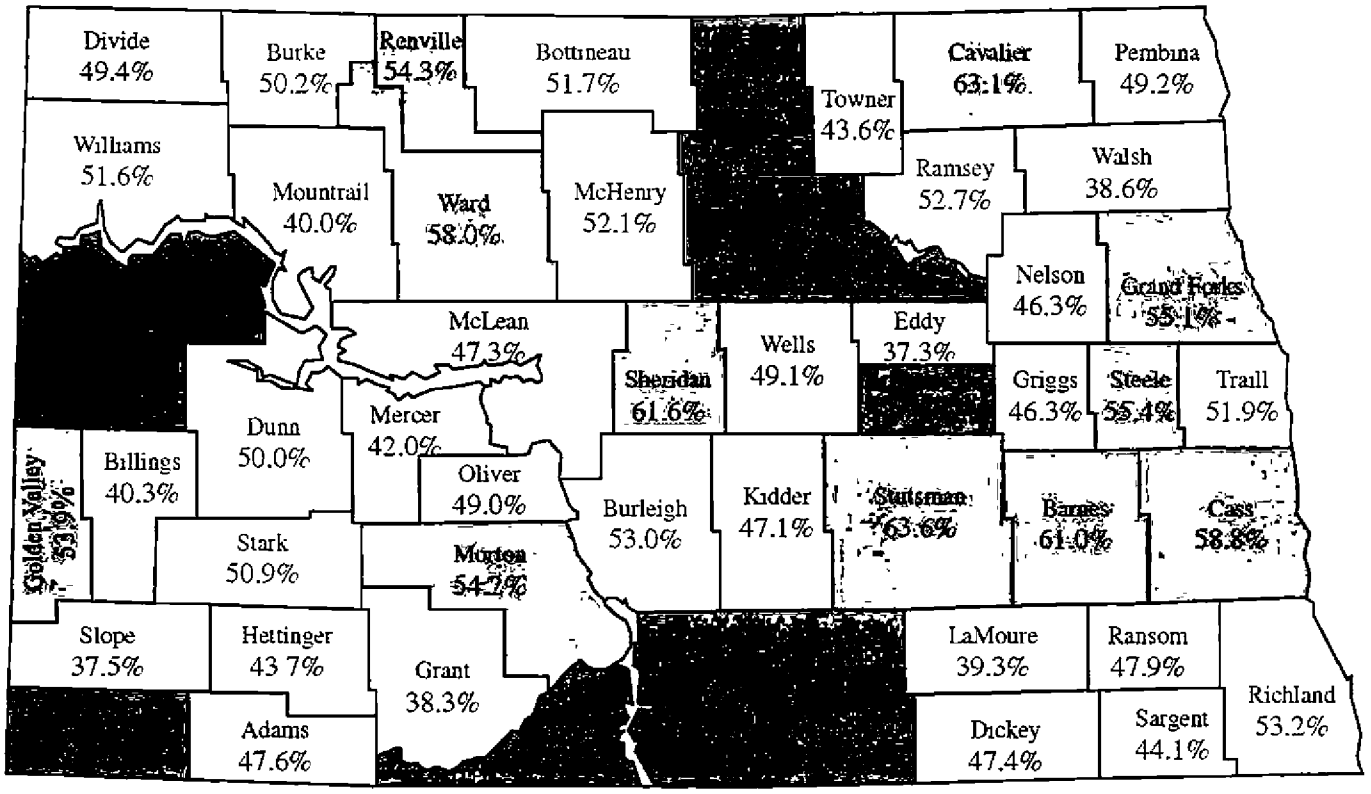


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

North Dakota Pneumococcal Pneumonia Vaccination Rates

Medicare Claims Data – Claims through 06/30/10

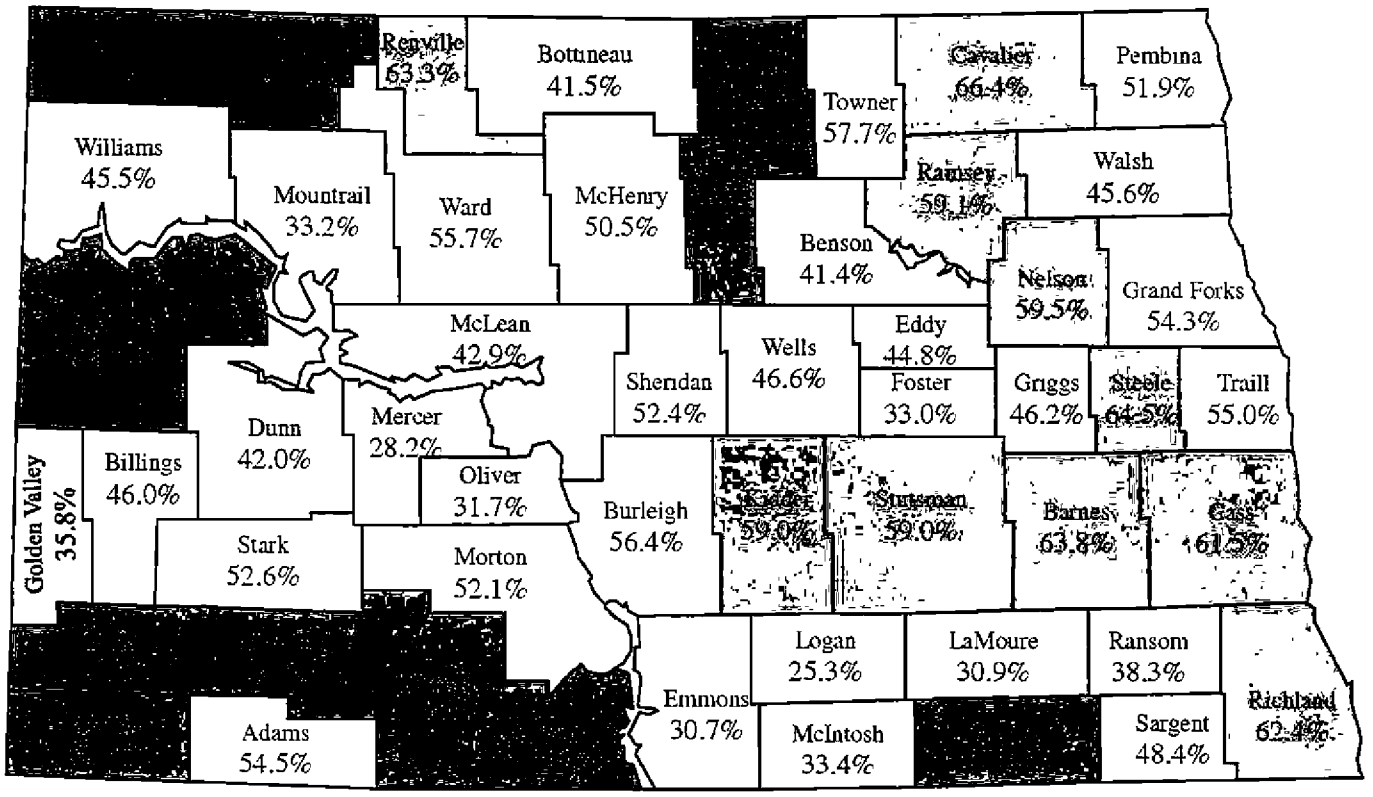


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

North Dakota Influenza Vaccination Rates

Medicare Claims Data – 03/01/09-03/31/10

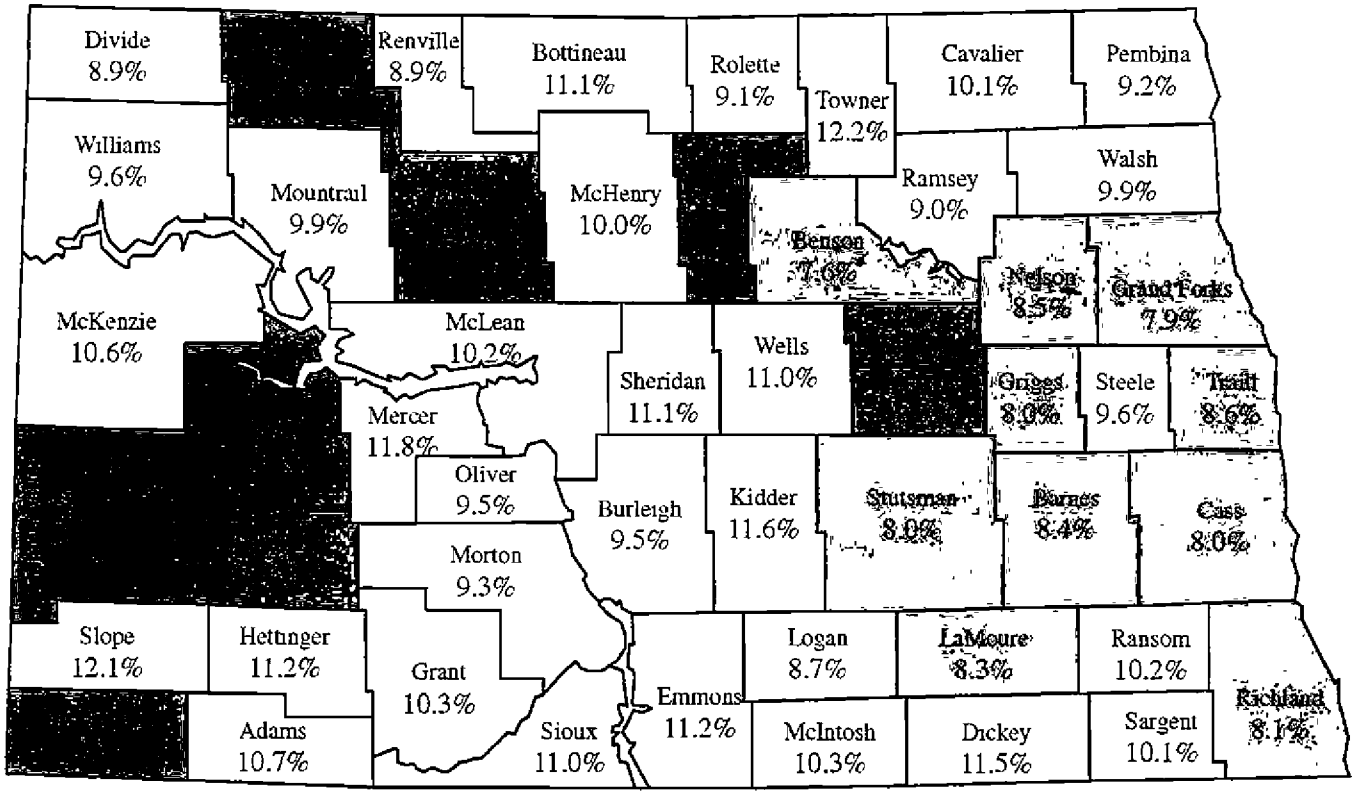


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

October 2010

North Dakota DDI Rates

Timeframe: 01/01/10-06/30/10; Data Source: Medicare Part D

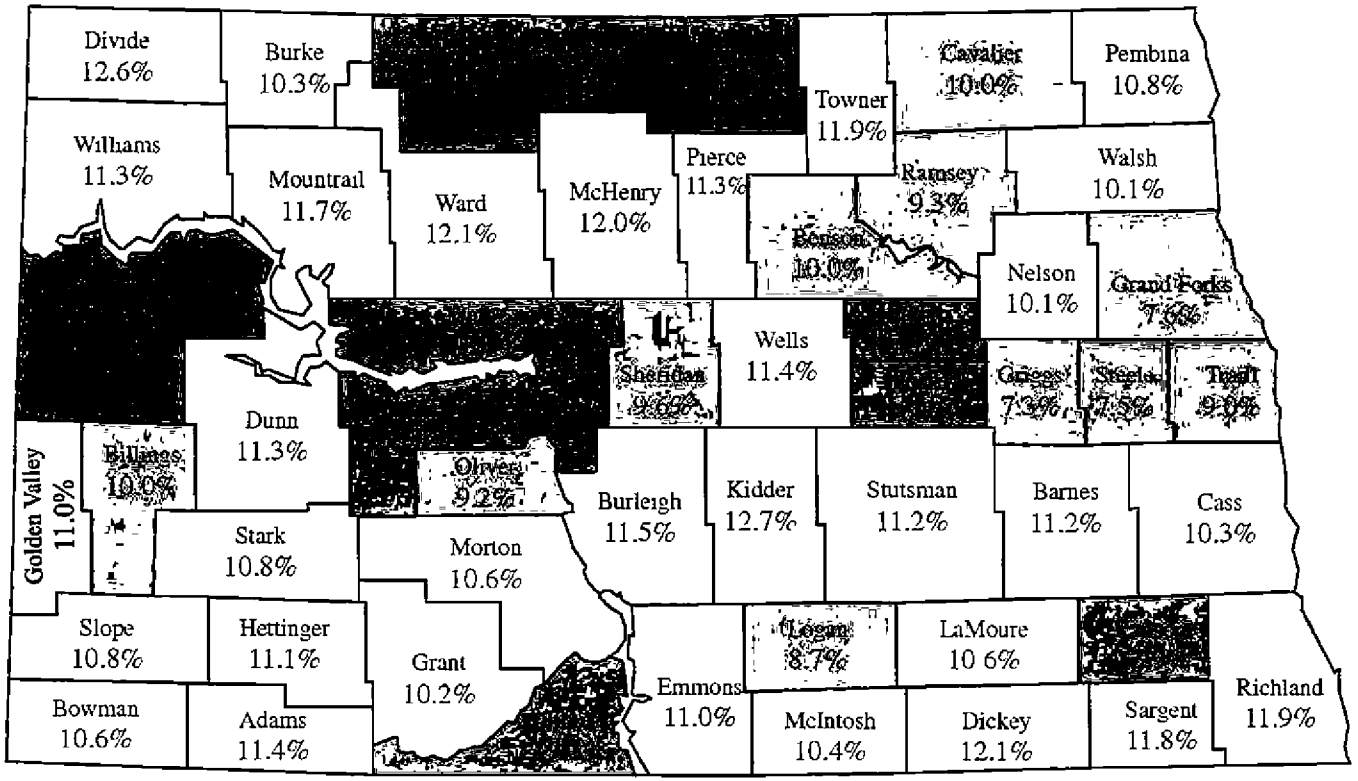


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

North Dakota PIM Rates

Timeframe: 01/01/10-06/30/10; Data Source: Medicare Part D

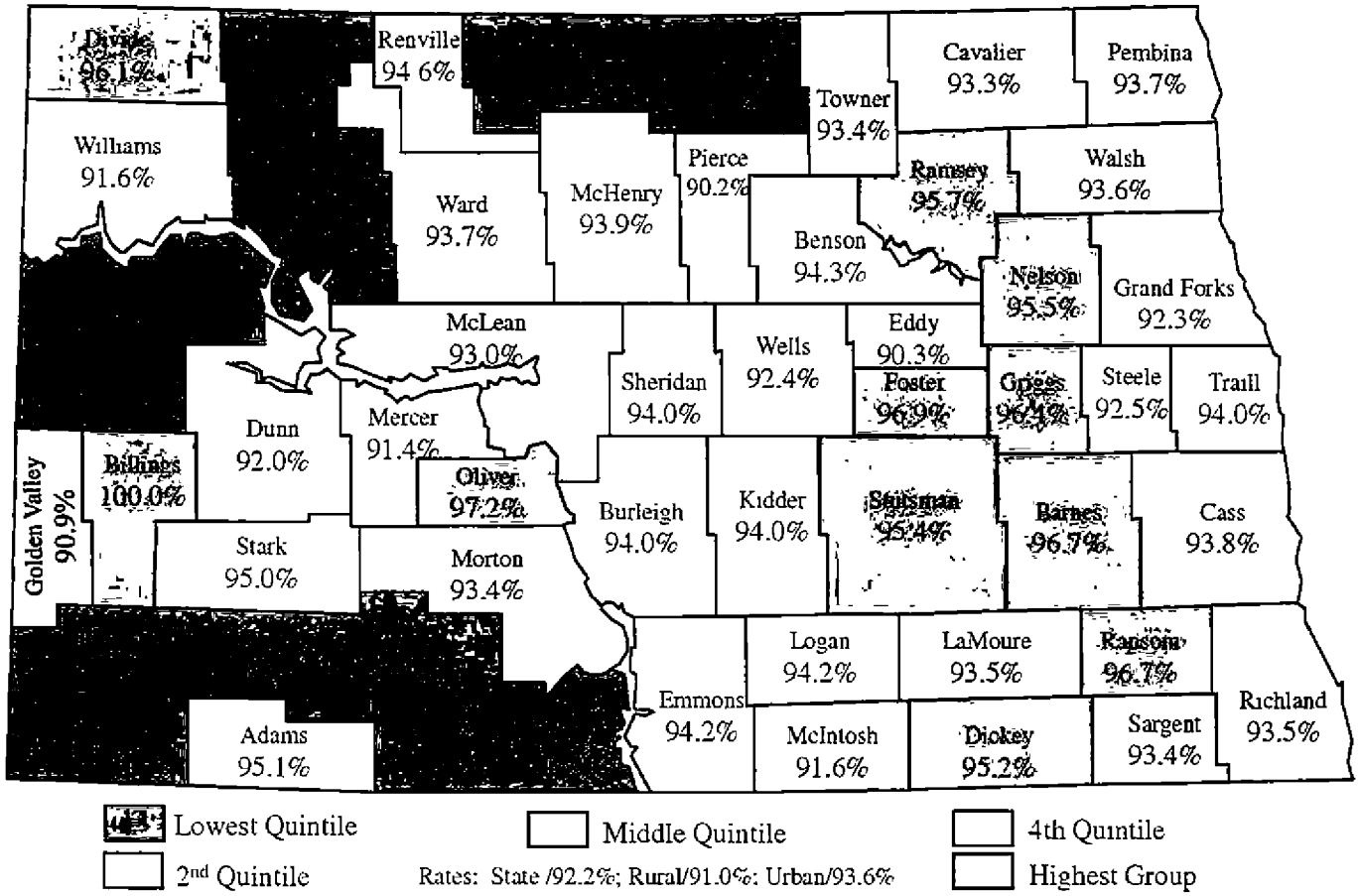


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Annual Hemoglobin A1C Screening Rates for Patients with Diabetes

Medicare Claims Data Quarter 10 – End date 06/30/10

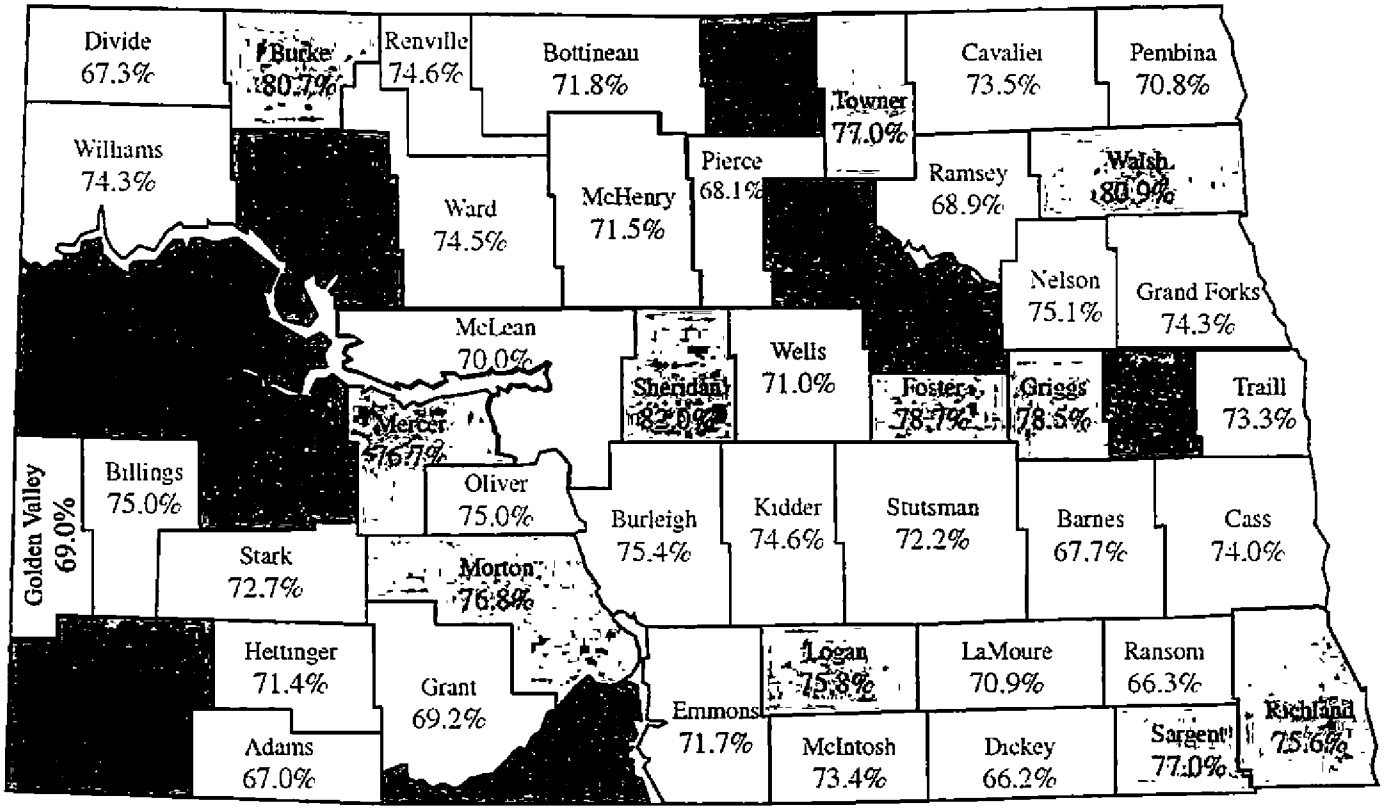


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Annual Eye Examination Screening Rates for Patients with Diabetes

Medicare Claims Data Quarter 10 – End date 06/30/10

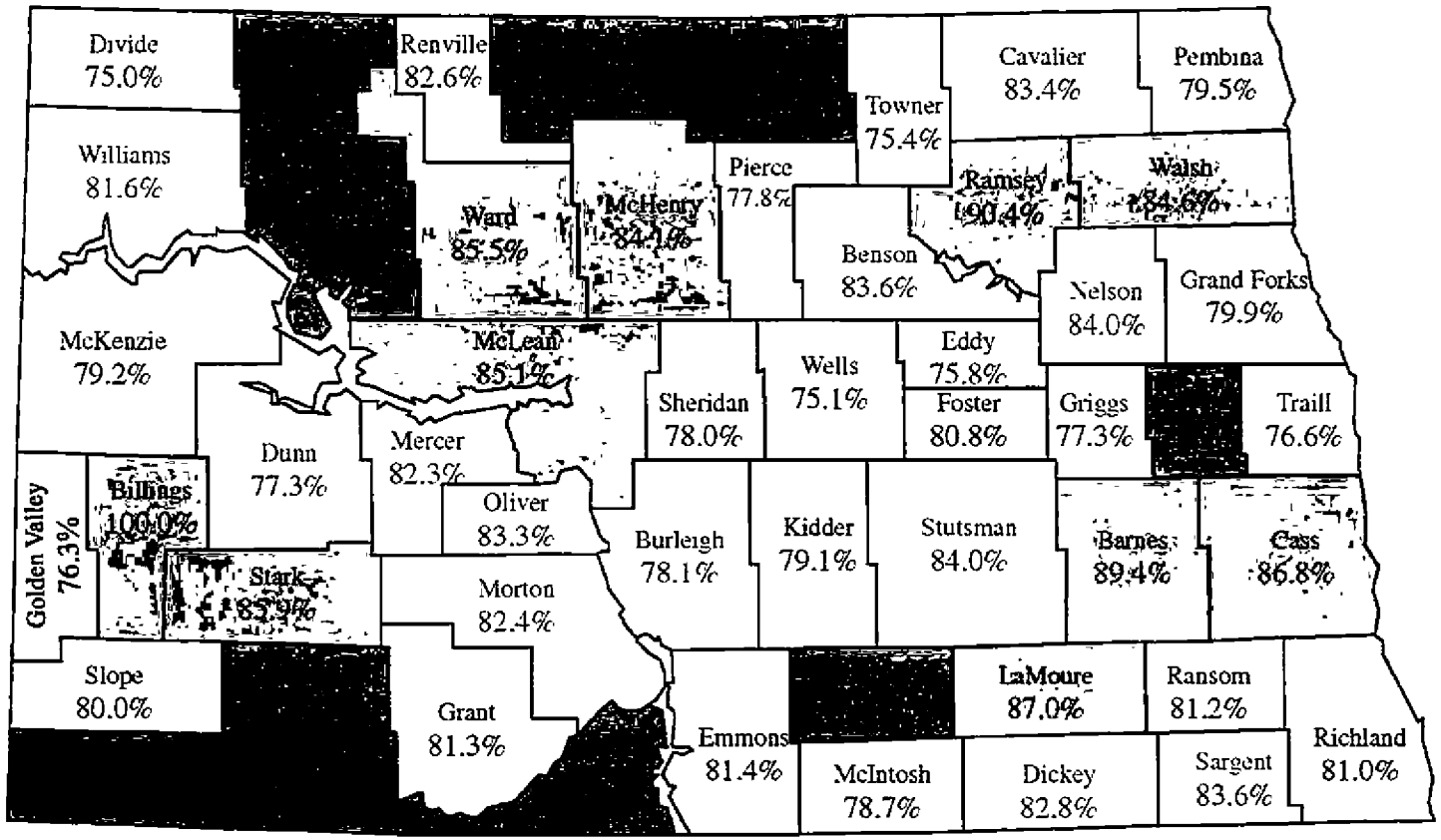


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Annual Lipid Testing Screening Rates for Patients with Diabetes

Medicare Claims Data Quarter 10 – End date 06/30/10



Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Appendix H – Prioritization of Community's Health Needs

Tier 1

- Financial viability of hospital (8 votes)
- Maintaining EMS (5 votes)

Tier 2

- Elevated rate of excessive drinking (4 votes)
- Cost of health care (4 votes)
- Cancer (4 votes)
- Aging population (4 votes)
- Elevated rate of uninsured residents (3 votes)
- Adequate number of providers/specialists (3 votes)
- Declining population (3 votes)
- Lack of employment opportunities/low wages (3 votes)

Tier 3

- Limited number of mental health care providers (2 votes)
- Not enough health care staff in general/maintaining enough workers (2 votes)
- Need for additional collaboration (2 votes)
- Elevated rate of adult smoking (1 vote)
- Elevated rate of adult obesity (1 vote)
- Elevated rate of physical inactivity (1 vote)
- Limited access to healthy foods (1 vote)
- Elevated rates of uninsured children (1 vote)
- Decreased child care capacity (1 vote)
- Heart disease (1 vote)
- Need for mental health services (1 vote)
- Need for home health care (1 vote)

(No Votes)

- Elevated rate of diabetics
- Elevated level of sexually transmitted diseases
- Elevated level of preventable hospital stays
- Limited access to recreational facilities
- Uninsured not getting care/low awareness of community care