11-98 FORM HCFA-2552-96 3690 (C

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO.: 41-4003	PERIOD: FROM 10-1-08 TO 9-30-09	WORKSHEET S, PARTS I & II
Intermediary use only: [ ] Audited [ ] Desk Reviewed	Date Received: _____ Intermediary No. _____	[ ] Initial [ ] Reopening [ ] Final	

PART I - CERTIFICATION

Check applicable box	[ ] Electronically filed cost report	Date: _____	Time: _____
	[X] Manually submitted cost report		

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by EP Bradley Hospital (Provider Names(s) and Number(s)) for the cost reporting period beginning 10-1-08 and ending 9-30-09 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) Mary G Wakefield
Officer or Administrator of Provider(s)
CFO
Title
2-25-10
Date

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX
		1	2	3	4
1	HOSPITAL				
2	SUBPROVIDER				
3	SWING BED - SNF				
4	SWING BED - NF				
5	SKILLED NURSING FACILITY				
6	NURSING FACILITY				
7	HOME HEALTH AGENCY				
8	OUTPATIENT REHABILITATION PROVIDER (specify)				
9	HEALTH CLINIC (specify)				
100	TOTAL	Ø	Ø	Ø	Ø

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated to average 657 hours per response, including the time to review instructions, search existing data resources, gather comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

FORM HCFA-2552-96 (11/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB 15-II, SECTIONS 3603-3603.2)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.: 41-4003	PERIOD: FROM 10-1-08 TO 9-30-09	WORKSHEET S-2

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O Box:		1
1.01	City: State:	Zip Code:	County:	1.01

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
2	Hospital	EP Bradley Hosp	41-4003	7-1-66				2
3	Subprovider							3
4	Swing Beds-SNF							4
5	Swing Beds-NF							5
6	Hospital-Based SNF							6
7	Hospital-Based NF							7
8	Hospital-Based OLTC							8
9	Hospital-Based HHA							9
11	Separately Certified ASC							11
12	Hospital-Based Hospice							12
14	Hospital-Based Health Clinic (specify)							14
15	Outpatient Rehab. Clinic (specify)							15
16	Renal Dialysis							16

17	Cost Reporting Period (mm/dd/yyyy)	From: 10-1-08	To: 9-30-09	17
		1	2	
18	Type of Control (see instructions)	Y		18
Type of hospital/subprovider (see instructions)				
19	Hospital			19
20	Subprovider			20
Other Information				
21	Indicate if your hospital is either (1) urban or (2) rural	N		21
21.01	Are you eligible for disproportionate share adjustment payments in accordance with 42 CFR 412.106? (see instructions)	N		21.01
22	Are you classified as a referral center?	N		22
23	Does this facility operate a transplant center?	N		23
23.01	If this is a Medicare certified kidney transplant center, enter the certification date (mm/dd/yyyy).		N/A	23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date (mm/dd/yyyy).		N/A	23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date (mm/dd/yyyy).		N/A	23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date (mm/dd/yyyy).		N/A	23.04
24	If this an organ procurement organization (OPO), enter the OPO number in column 2.		N/A	24
25	Is this a teaching hospital?	Y		25
25.01	Is this teaching program approved in accordance with HCFA Pub. 15-I, chapter 4?	Y		25.01
25.02	If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If yes, complete Worksheet E-3, Part IV. If no, complete Worksheet D-2, Part II.	N/A		25.02
25.03	As a teaching hospital, did you elect cost reimbursement for physicians' services as defined in HCFA Pub. 15-I, section 2148? If yes, complete Worksheet D-9.	N/A		25.03
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N/A		25.04
26	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect. Enter beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 for number of periods in excess of one and enter subsequent dates.	N/A		26
26.01	Enter the applicable SCH dates: Beginning: Ending:			26.01
27	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		27

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.: 41-4003	PERIOD: FROM 10-1-08 TO 9-30-09	WORKSHEET S-2 (CONT.)

28	Does this facility contain a hospital-based SNF which has been granted an exemption from the cost limits in accordance with 42 CFR 413.30(e)?	N/A		28
29	Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement?	N/A		29
30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CFR 485.606ff)	N/A		30
30.01	If so, is this the initial 12 month period for the facility operated as an RPCH/CAH? See 42 CFR 413.70.	N/A		30.01
30.02	If this facility qualifies as an RPCH, has it elected the all-inclusive method of payment for outpatient services?	N/A		30.02
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).	N/A		31

Miscellaneous Cost Reporting information

32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.	N/A		32
33	Is this a new hospital under 42 CFR 412.300 PPS capital?	N		33
34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?	N		34
35	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?	N		35

		V	XVIII	XIX	
		1	2	3	
	Prospective Payment System (PPS)-Capital				
36	Do you elect fully prospective payment methodology for capital costs?	N/A	N/A	N/A	36
36.01	Are you eligible for disproportionate share payments in accordance with 42 CFR 412.320? (see instru.)	N/A	N/A	N/A	36.01
37	Do you elect hold harmless payment methodology for capital costs?	N/A	N/A	N/A	37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?	N/A	N/A	N/A	37.01

Title XIX inpatient services

38	Do you have title XIX inpatient hospital services?	Y		38
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?	N		38.01
38.02	Does the title XIX program reduce capital following the Medicare methodology?	N		38.02
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions)	N		38.03
38.04	Do you operate an ICF\MR facility for purposes of title XIX?	N		38.04

40	Are there any related organization or home office costs as defined in HCFA Pub. 15-I, chapter 10?	Y		40
41	Are provider based physicians' costs included in Worksheet A?	N		41
42	Are physical therapy services provided by outside suppliers?	N		42
42.01	Are occupational therapy services provided by outside suppliers?	N		42.01
42.02	Are speech pathology services provided by outside suppliers?	N		42.02
43	Are respiratory therapy services provided by outside suppliers?	N		43
44	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?	N		44
45	Have you changed your cost allocation methodology from the previously filed cost report? See HCFA Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		45
45.01	Was there a change in the statistical basis?	N		45.01
45.02	Was there a change in the order of allocation?	N		45.02
45.03	Was the change to the simplified cost finding method?	N		45.03
46	If you are participating in the NHCMQ demonstration project (must have a hospital-based SNF) during this cost reporting period, enter the phase (see instructions).	N/A		46

If this facility contains a provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption. Enter "N" if not exempt. (See 42 CFR 413.13.)

		Part A	Part B	Outpatient ASC	Outpatient Radiology	Outpatient Diagnostic	
		1	2	3	4	5	
47	Hospital						47
48	Subprovider						48
49	SNF						49
50	HHA						50
51	Outpatient Rehab. Providers(specify)						51

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.: 41-4003	PERIOD: FROM 10-1-08 TO 9-30-09	WORKSHEET S-2 (CONT.)

52	Does this hospital claim expenditures for extraordinary circumstances inaccordance with 42 CFR 412.348(e)? (see instructions)	N/A		52
53	If this is a medicare dependent hospital (MDH), enter the number of periods MDH status in effect. Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 for number of periods in excess of one and enter subsequent dates.	N/A		53
53.01	MDH period beginning: ending:			53.01
54	List amounts of malpractice premiums and paid losses: Premiums: N/A Paid losses: N/A and/or Self insurance:			54
54.01	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N/A		54.01
55	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.	N/A		55
56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit provided from your intermediary.	N/A		56

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
STATISTICAL DATA

PROVIDER NO.: 41-4003

PERIOD FROM 10-1-08 TO 9-30-09

WORKSHEET S-3, PART I

	Component	No. of Beds	Bed Days Available	I/P Days / O/P Visits / Trips				Interns & Residents FTEs			Full Time Equivalent		Discharges				
				Title V	Title XVIII	Title XIX	Total All Patients	Total	Less I & R Replacing Non-Phys. Anesthetist	Net	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 3, 4, and 5), exclude Swing Bed, Observation Bed, and Hospice Days.																1
2	HMO																2
3	Hospital Adults & Peds. Swing Bed SNF																3
4	Hospital Adults & Peds. Swing Bed NF																4
5	Total Adults and Peds. (exclude observation beds) (see instructions)																5
6	Intensive Care Unit																6
7	Coronary Care Unit																7
8	Burn Intensive Care Unit																8
9	Surgical Intensive Care Unit																9
10	Other Special Care	60	21,900	—	—	9,567	19,423										10
11	Nursery																11
12	Total (see instructions)	60	21,900	—	—	9,567	19,423	9	—	—	579	Ø	—	—	117	1233	12
13	RPCH visits																13
14	Subprovider																14
15	Skilled Nursing Facility																15
16	Nursing Facility																16
17	Other Long Term Care																17
18	Home Health Agency																18
20	ASC (Distinct Part)																20
21	Hospice (Distinct Part)																21
23	Oupatient Rehab. Provider (specify)																23
24	RHC/FQHC (specify)																24
25	Total (sum of lines 12-24)	60						9	—	—	579	Ø					25
26	Observation Bed Days						Ø										26
27	Ambulance Trips				Ø												27

FORM HCFA-2552-96 (11/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 3605.1)

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

PROVIDER NO.: 41-4003 | PERIOD: FROM 10-1-08 TO 9-30-09 | WORKSHEET G

	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,874,437				1
2	Temporary investments	—				2
3	Notes receivable	—				3
4	Accounts receivable	11,876,293				4
5	Other receivables	1080,194				5
6	Allowances for uncollectible notes and accounts receivable	(780,879)				6
7	Inventory	126,903				7
8	Prepaid expenses	4,325				8
9	Other current assets	—				9
10	Due from other funds	—				10
11	Total current assets (sum of lines 1-10)	16,781,273	Ø	Ø	Ø	11
	FIXED ASSETS					
12	Land	1,018,000				12
12.01	Accumulated depreciation	—				12.01
13	Land improvements	—				13
13.01	Accumulated depreciation	—				13.01
14	Buildings	44,546,380				14
14.01	Accumulated depreciation	(9,024,199)				14.01
15	Leasehold improvements	610,278				15
15.01	Accumulated depreciation	(610,278)				15.01
16	Fixed equipment	—				16
16.01	Accumulated depreciation	—				16.01
17	Automobiles and trucks	—				17
17.01	Accumulated depreciation	—				17.01
18	Major movable equipment	9,649,257				18
18.01	Accumulated depreciation	(7,585,617)				18.01
19	Minor equipment depreciable	—				19
19.01	Accumulated depreciation	—				19.01
20	Minor equipment-nondepreciable	—				20
21	Total fixed assets (sum of lines 12-20)	38,603,822	Ø	Ø	Ø	21
	OTHER ASSETS					
22	Investments	—				22
23	Deposits on leases	—				23
24	Due from owners/officers	—				24
25	Other assets	59,754,744				25
26	Total other assets (sum of lines 22-25)	59,754,744				26
27	Total assets (sum of lines 11, 21, and 26)	115,139,838	Ø	Ø	Ø	27

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

PROVIDER NO.: 41-4003

PERIOD: FROM 10-1-08 TO 9-30-09

WORKSHEET G (CONT.)

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
28	Accounts payable	1,649,829				28
29	Salaries, wages, and fees payable	2,939,592				29
30	Payroll taxes payable	—				30
31	Notes and loans payable (short term)	—				31
32	Deferred income	—				32
33	Accelerated payments	—				33
34	Due to other funds	—				34
35	Other current liabilities	1,189,757				35
36	Total current liabilities (sum of lines 28 thru 35)	5,779,178	Ø	Ø	Ø	36
	LONG TERM LIABILITIES					
37	Mortgage payable					37
38	Notes payable BOND 09	23,037,450				38
39	Unsecured loans					39
40	Loans from owners .01 Prior to 7/1/66					40.01
	.02 On or after 7/1/66					40.02
41	Other long term liabilities 3rd Party	8,072,428				41
42	Total long term liabilities (sum of lines 37 thru 41)	31,109,878				42
43	Total liabilities (sum of lines 36 and 42)	36,889,056	Ø	Ø	Ø	43
	CAPITAL ACCOUNTS					
44	General fund balance	26,336,957				44
45	Specific purpose fund		4,668,643			45
46	Donor created - endowment fund balance - restricted			47,245,182		46
47	Donor created - endowment fund balance - unrestricted			—		47
48	Governing body created - endowment fund balance			—		48
49	Plant fund balance - invested in plant				—	49
50	Plant fund balance - reserve for plant improvement, replacement, and expansion				—	50
51	Total fund balances (sum of lines 44 thru 50)	26,336,957	4,668,643	47,245,182		51
52	Total liabilities and fund balances (sum of lines 43 and 51)	63,226,013	4,668,643	47,245,182	Ø	52

10-96

FORM HCFA-2552-96

3690 (Cont.)

STATEMENT OF CHANGES IN FUND BALANCES

PROVIDER NO.: 41-4003

PERIOD: FROM 10-1-08 TO 9-30-09

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND	PLANT FUND			
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period		28,762,000		51,914,000		Ø		Ø	1
2	Net income (loss) (from Wkst. G-3, line 31)		2,860,000							2
3	Total (sum of line 1 and line 2)		31,622,000		51,914,000		Ø		Ø	3
4	Additions (credit adjustments) (specify)									4
5	Restricted for PP+E	1,344,000		—						5
6	Transfers from Unrestr. Net Assets	—		152,000						6
7	Transfers from Foundation	—		2,399,000						7
8	Restricted Grants + Gifts	—		2,799,000						8
9				—			Ø		Ø	9
10	Total additions (sum of lines 4-9)		1,344,000		5,350,000		Ø		Ø	10
11	Subtotal (line 3 plus line 10)		32,966,000		57,264,000					11
12	Deductions (debit adjustments) (specify) Chg in FASB 158	(257,000)		—						12
13	Change in Funded Status of Pension	(3,490,000)		—						13
14	Decr in Interest in Net Assets	—		(1,264,000)						14
15	Trans. to Perm. Restricted Assets	(152,000)		—						15
16	Net Unrealized Losses on Invest.	—		2890,000						16
17	Net Assets Released from Restriction	—		(3926,000)			Ø		Ø	17
18	Total deductions (sum of lines 12-17)		(3,899,000)		(8,080,000)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,067,000		49,184,000		Ø		Ø	19

FORM HCFA-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 3640)

STATEMENT OF PATIENT REVENUES AND OPERATING REVENUES	PROVIDER NO.: 41-4003	PERIOD: FROM 10-1-08 TO 9-30-09	WORKSHEET G-2, PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital				1
2	Subprovider				2
4	Swing bed - SNF				4
5	Swing bed - NF				5
6	Skilled nursing facility				6
7	Nursing facility				7
8	Other long term care				8
9	Total general inpatient care services (sum of lines 1-8)				9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	Intensive care unit				10
11	Coronary care unit				11
12	Burn intensive care unit				12
13	Surgical intensive care unit				13
14	Other special care (specify) Psych	37,809,000		37,809,000	14
15	Total intensive care type inpatient hospital services (sum of of lines 10-14)	37,809,000		37,809,000	15
16	Total inpatient routine care services (sum of lines 9 and 15)	37,809,000		37,809,000	16
17	Ancillary services	4,151,000	2,828,000	6,979,000	17
18	Outpatient services	—	1,171,000		18
19	Home health agency				19
20	Ambulance				20
21	Outpatient rehabilitation providers				21
22	ASC				22
23	Hospice				23
24	Residential + School		22,053,000		24
25	Total patient revenues (sum of lines 16-24) (transfer column 3 to Wkst. G-3, line 1)	41,960,000	26,052,000	68,012,000	25

PART II - OPERATING EXPENSES

		1	2	
26	Operating expenses (per Wkst. A, column 3, line 101)		58,053,000	26
27	Add (specify)			27
28				28
29				29
30				30
31				31
32				32
33	Total additions (sum of lines 27-32)		Ø	33
34	Deduct (specify)			34
35				35
36				36
37				37
38				38
39	Total deductions (sum of lines 34-38)		Ø	39
40	Total operating expenses (sum of lines 26 and 33 minus line 39) (transfer to Wkst. G-3, line 4)		58,053,000	40

STATEMENT OF REVENUES AND EXPENSES	PROVIDER NO.: 41-4003	PERIOD: FROM 10-1-08 TO 9-30-09	WORKSHEET G-3

	Description		
1	Total patient revenues (from Wkst. G-2, Part I, column 3, line 25)	68,012,000	1
2	Less contractual allowances and discounts on patients' accounts	13,128,000	2
3	Net patient revenues (line 1 minus line 2)	54,884,000	3
4	Less total operating expenses (from Wkst. G-2, Part II, line 40)	58,053,000	4
5	Net income from service to patients (line 3 minus line 4)	(3,169,000)	5
	OTHER INCOME		
6	Contributions, donations, bequests, etc	—	6
7	Income from investments	—	7
8	Revenues from telephone and telegraph service	—	8
9	Revenue from television and radio service	—	9
10	Purchase discounts	—	10
11	Rebates and refunds of expenses	—	11
12	Parking lot receipts	—	12
13	Revenue from laundry and linen service	—	13
14	Revenue from meals sold to employees and guests	123,000	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops, and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (specify) Endowment, Restricted Funds	5,906,000	24
25	Total other income (sum of lines 6-24)	6,029,000	25
26	Total (line 5 plus line 25)	2,860,000	26
27	Other expenses (specify)		27
28			28
29			29
30	Total other expenses (sum of lines 27-29)	Ø	30
31	Net income (or loss) for the period (line 26 minus line 30)	2,860,000	31