Ashland Hospital District No. 3

Independent Auditor's Report and Financial Statements

December 31, 2012 and 2011

BKD LLP
CPAs & Advisors

Ashland Hospital District No. 3

December 31, 2012 and 2011

Contents

BKD LLP
CPAs & Advisors

1551 N. Waterfront Parkway, Suite 300
Wichita, KS 67206-6601
316.265.2811 Fax 316.265.9405 www.bkd.com

Independent Auditor's Report

Board of Trustees
Ashland Hospital District No. 3
Ashland, Kansas

We have audited the accompanying financial statements of Ashland Hospital District No. 3, which comprise of the balance sheets as of December 31, 2012 and 2011, and the related statements of revenues, expenses and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of 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 financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the provisions of the Kansas Municipal Audit and Accounting Guide. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 financial statements.

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Ashland Hospital District No. 3 as of December 31, 2012 and 2011, and the changes in its financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Required Supplementary Information

Management has omitted management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. Our opinion on the basic financial statements is not affected by this missing information.

BKD, LLP

Wichita, Kansas
May 29, 2013

Ashland Hospital District No. 3
Balance Sheets
December 31, 2012 and 2011

	2012	2011
Assets		
Current Assets		
Cash	$ 883,292	$ 205,241
Patient accounts receivable, net	461,173	382,228
Property taxes receivable	1,044,790	1,059,464
Estimated amounts due from third-party payers	50,000	545,000
Supplies	111,863	116,540
Prepaid expenses and other	64,086	42,742
Total current assets	2,615,204	2,351,215
Noncurrent Cash	225,653	28,354
Capital Assets		
Land	14,560	14,560
Depreciable capital assets, net of accumulated depreciation	825,908	971,729
Total capital assets, net of accumulated depreciation	840,468	986,289
Total assets	$ 3,681,325	$ 3,365,858
Liabilities and Net Position		
Current Liabilities		
Current portion of long-term debt	$ 89,771	$ 74,147
Accounts payable	296,796	403,709
Accrued wages and payroll taxes	162,721	139,643
Accrued paid time off	78,388	68,119
Accrued interest payable	3,625	4,375
Deferred property taxes revenue	1,044,790	1,059,464
Estimated amounts due to third-party payers	450,000	-
Total current liabilities	2,126,091	1,749,457
Long-term Debt	134,700	153,234
Total liabilities	2,260,791	1,902,691
Net Position		
Net investments in capital assets	615,997	758,908
Restricted - expendable for specific operating activities	12,251	15,868
Unrestricted	792,286	688,391
Total net position	1,420,534	1,463,167
Total liabilities and net position	$ 3,681,325	$ 3,365,858

Ashland Hospital District No. 3

Statements of Revenues, Expenses and Changes in Net Position

Years Ended December 31, 2012 and 2011

	2012	2011
Operating Revenues		
Net patient service revenue	$ 4,573,803	$ 4,193,144
Electronic health records incentive revenue	201,430	-
Other	119,169	105,861
Total operating revenues	4,894,402	4,299,005
Operating Expenses		
Salaries	2,918,163	2,571,998
Supplies and other	2,788,343	2,731,277
Depreciation	275,656	221,158
Total operating expenses	5,982,162	5,524,433
Operating Loss	(1,087,760)	(1,225,428)
Nonoperating Revenues (Expenses)		
Property taxes	1,040,956	1,083,018
Noncapital grants and contributions	13,870	26,531
Interest income	2,454	6,640
Interest expense	(12,153)	(14,414)
Total nonoperating revenues (expenses)	1,045,127	1,101,775
Change in Net Position	(42,633)	(123,653)
Net Position, Beginning of Year	1,463,167	1,586,820
Net Position, End of Year	$ 1,420,534	$ 1,463,167

Ashland Hospital District No. 3
Statements of Cash Flows
Years Ended December 31, 2012 and 2011

	2012	2011
Operating Activities		
Receipts from and on behalf of patients	$ 5,439,858	$ 3,734,994
Payments to employees	(2,884,816)	(2,503,414)
Payments to suppliers and contractors	(2,911,923)	(2,457,099)
Electronic health records incentive revenue	201,430	-
Other receipts, net	119,169	105,861
Net cash used in operating activities	(36,282)	(1,119,658)
Investing Activities		
Interest income	2,454	6,640
Noncapital Financing Activities		
Property taxes	1,040,956	1,083,018
Noncapital grants and contributions	13,870	26,531
Net cash provided by noncapital financing activities	1,054,826	1,109,549
Capital and Related Financing Activities		
Purchases of capital assets	(26,188)	(330,369)
Interest paid on long-term debt	(12,903)	(15,164)
Principal paid on long-term debt	(106,557)	(78,213)
Net cash used in capital and related financing activities	(145,648)	(423,746)
Increase (Decrease) in Cash	875,350	(427,215)
Cash, Beginning of Year	233,595	660,810
Cash, End of Year	$ 1,108,945	$ 233,595
Reconciliation of Cash to the Balance Sheets		
Cash in current assets	$ 883,292	$ 205,241
Cash in noncurrent assets	225,653	28,354
Total cash	$ 1,108,945	$ 233,595

Ashland Hospital District No. 3
Statements of Cash Flows (Continued)
Years Ended December 31, 2012 and 2011

	2012	2011
Reconciliation of Operating Loss to Net Cash Used in Operating Activities		
Operating loss	$ (1,087,760)	$ (1,225,428)
Depreciation	275,656	221,158
Provision for uncollectible accounts	85,444	55,641
Change in assets and liabilities		
Patient accounts receivable	(164,389)	18,625
Estimated amounts due to/from third-party payers	945,000	(532,416)
Supplies	4,677	(2,608)
Prepaid expenses	(21,344)	(16,684)
Accounts payable	(106,913)	293,470
Other accrued liabilities	33,347	68,584
Net cash used in operating activities	$ (36,282)	$ (1,119,658)
Supplemental Cash Flows Information		
Capital lease obligation incurred for capital assets	$ 103,647	$ -

Ashland Hospital District No. 3

Notes to Financial Statements

December 31, 2012 and 2011

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations and Reporting Entity

Ashland Hospital District No. 3 (Hospital District) is a political subdivision of the State of Kansas. The Hospital District operates the Ashland Health Center which consists of an acute care hospital, long-term care unit, clinic and independent living facility located in Ashland, Kansas. The Hospital District is governed by a Board of Trustees consisting of five members elected by residents of the Hospital District.

Basis of Accounting and Presentation

The financial statements of the Hospital District have been prepared on the accrual basis of accounting using the economic resources measurement focus. Revenues, expenses, gains, losses, assets and liabilities from exchange and exchange-like transactions are recognized when the exchange transaction takes place, while those from government-mandated nonexchange transactions (principally tax appropriations) are recognized when all applicable eligibility requirements are met. Operating revenues and expenses include exchange transactions and program-specific, government-mandated nonexchange transactions. Government-mandated nonexchange transactions that are not program specific (such as tax appropriations), interest income and interest on capital assets-related debt are included in nonoperating revenues and expenses. The Hospital District first applies restricted net position when an expense or outlay is incurred for purposes for which both restricted and unrestricted net position are available.

The Hospital District prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB).

Use of Estimates

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

Cash Equivalents

The Hospital District considers all liquid investments with original maturities of three months or less to be cash equivalents. There were no cash equivalents at December 31, 2012 and 2011.

Pursuant to legislation enacted in 2010, the FDIC fully insured all noninterest-bearing transaction accounts beginning December 31, 2010 through December 31, 2012, at all FDIC-insured institutions. This legislation expired on December 31, 2012. Beginning January 1, 2013, noninterest-bearing transaction accounts are subject to the $250,000 limit on FDIC insurance per covered institution.

Budgetary Principles

The Hospital District is required by state statutes to adopt an annual budget for its general funds on or before August 25 for the ensuing year. The Hospital District's Board of Trustees may amend the budget by transferring budgeted amounts from one object or purpose to another within the same fund. Expenditures may not legally exceed the total amount of the adopted budget of individual funds.

Property Taxes

The Hospital District received approximately 18% and 20% of its financial support from property taxes in 2012 and 2011, respectively. One hundred percent of these funds were used to support operations in both years.

In accordance with governing state statutes, property taxes levied during the current year are a revenue source to be used to finance the budget of the ensuing year. Taxes are assessed on a calendar year tax basis and become a lien on the property on November 1 of each year. The county treasurer is the tax collection agent for all taxing entities within the county. Property owners have the option of paying one-half or the full amount of the taxes levied on or before December 20 during the year levied with the balance to be paid on or before May 10 of the ensuing year. State statutes prohibit the county treasurer from distributing taxes collected in the year levied prior to January 1 of the ensuing year. Consequently, for revenue recognition purposes, the taxes levied during the current year are not due and receivable until the ensuing year. At December 31, such taxes are a lien on the property and are recorded as property taxes receivable, net of anticipated delinquencies, with a corresponding amount recorded as deferred property tax revenue on the balance sheets.

Risk Management

The Hospital District is exposed to various risks of loss from torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Patient Accounts Receivable

Accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of accounts receivable, the Hospital District analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for uncollectible accounts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts.

For receivables associated with services provided to patients who have third-party coverage, the Hospital District analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for uncollectible accounts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payer has not yet paid, or for payers 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 Hospital District records a significant provision for uncollectible 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 or provided by policy) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts.

The Hospital District's allowance for uncollectible accounts estimated at December 31, 2012, is based primarily on 100% of self-pay account balances greater than 90 days from the date of discharge or service.

Supplies

Supply inventories are stated at the lower of cost, determined using the first-in, first-out method, or market.

Capital Assets

Capital assets are recorded at cost at the date of acquisition, or fair value at the date of donation if acquired by gift. Depreciation is computed using the straight-line method over the estimated useful life of each asset. Assets under capital lease obligations are depreciated over the shorter of the lease term or their respective estimated useful lives. The following estimated useful lives are being used by the Hospital District:

Land improvements	5-15 years
Buildings	10-33 years
Fixed equipment	5-25 years
Moveable equipment	3-15 years

The costs of maintenance and repairs are charged to operating expenses as incurred. The costs of significant additions, renewals and betterments to depreciable properties are capitalized and depreciated over the remaining or extended estimated useful lives of the item or the properties. When depreciable property is retired or otherwise disposed of, the related costs and accumulated depreciation are removed from the accounts and any gain or loss is reflected in nonoperating revenues (expenses).

Compensated Absences

Hospital District policies permit most employees to accumulate vacation and sick leave benefits that may be realized as paid time off or, in limited circumstances, as a cash payment. Expense and the related liability are recognized as vacation benefits are earned whether the employee is expected to realize the benefit as time off or in cash. Expense and the related liability for sick leave benefits are recognized when earned to the extent the employee is expected to realize the benefit in cash determined using the termination payment method. Sick leave benefits expected to be realized as paid time off are recognized as expense when the time off occurs and no liability is accrued for such benefits employees have earned but not yet realized. Compensated absence liabilities are computed using the regular pay in effect at the balance sheet date.

Net Position

The Hospital District's net position is classified in three components. Net investment in capital assets consists of capital assets, net of accumulated depreciation and reduced by the outstanding balances of borrowings used to finance the purchase of those assets. Restricted expendable net position represents noncapital assets that must be used for a particular purpose as specified by donors external to the Hospital District. Unrestricted net position represents remaining assets less remaining liabilities that do not meet the above conditions.

Net Patient Service Revenue

The Hospital District has agreements with third-party payers that provide for payments to the Hospital District at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered and includes estimated retroactive revenue adjustments and a provision for uncollectible accounts. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such estimated amounts are revised in future periods as adjustments become known.

Charity Care

The Hospital District provides care without charge or at amounts less than its established rates to patients meeting certain criteria under its charity care policy. Because the Hospital District does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as net patient service revenue.

Electronic Health Records Incentive Program

The Electronic Health Records Incentive Program, enacted as part of the *American Recovery and Reinvestment Act of 2009*, provides for one-time incentive payments under both the Medicare and Medicaid programs to eligible hospitals that demonstrate meaningful use of certified electronic health records technology (EHR). Critical access hospitals are eligible to receive incentive payments for up to four years under the Medicare program for its reasonable costs of the purchase of certified EHR technology multiplied by the Hospital District's Medicare utilization plus 20%, limited to 100% of the costs incurred. Payments under the Medicaid program are generally made for up to four years based upon a statutory formula, as determined by the state, which is approved by the Centers for Medicare and Medicaid Services (CMS). Payment under both programs are contingent on the hospital continuing to meet escalating meaningful use criteria and any other specific requirements that are applicable for the reporting period. The final amount for any payment year under both programs is determined based upon an audit by the fiscal intermediary. Events could occur that would cause the final amounts to differ materially from the initial payments under the program.

The Hospital District will recognize revenue ratably over the reporting period starting at the point when management is reasonably assured it will meet all of the meaningful use objectives and any other specific grant requirements applicable for the reporting period.

In 2012, electronic health records meaningful use requirements were met for the Hospital District. As a result, the Hospital District received and recorded revenue of $201,430.

Income Taxes

As an essential government entity, the Hospital District is generally exempt from federal and state income taxes under Section 115 of the Internal Revenue Code and a similar provision of state law.

Subsequent Events

Subsequent events have been evaluated through the date of the Independent Auditor's Report, which is the date the financial statements were available to be issued.

Note 2: Deposits

Custodial credit risk is the risk that in the event of a bank failure, a government's deposits may not be returned to it. The Hospital District's deposit policy for custodial credit risk requires compliance with the provisions of state law.

State law requires collateralization of all deposits with federal depository insurance and other acceptable collateral having an aggregate value at least equal to the amount of the deposits.

At December 31, 2012 and 2011, none of the Hospital District's deposits (checking and savings accounts) were exposed to custodial credit risk.

The carrying amounts of deposits are included in the Hospital District's balance sheet captions as follows at December 31, 2012 and 2011:

	2012	2011
Cash in current assets	$ 882,976	$ 204,925
Noncurrent cash		
Board-designated	213,402	12,486
Restricted by others	12,251	15,868
	225,653	28,354
	$ 1,108,629	$ 233,279

Note 3: Patient Accounts Receivable, Net/Net Patient Service Revenue

The Hospital District recognizes patient service revenue associated with services provided to patients who have third-party payer coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital District recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, a significant portion of the Hospital District's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital District records a significant provision for uncollectible accounts related to uninsured patients in the period the services are provided. This provision for uncollectible accounts is presented as a component of net patient service revenue.

The Hospital District has agreements with third-party payers that provide for payments to the Hospital District at amounts different from its established rates. These payment arrangements include:

Medicare. The Hospital District is recognized as a Critical Access Hospital (CAH). Under CAH rules, inpatient acute care, skilled swing-bed and certain outpatient services rendered to Medicare program beneficiaries are paid at one hundred one percent (101%) of allowable cost subject to certain limitations. Other outpatient services related to Medicare beneficiaries are paid based on a combination of fee schedules and cost reimbursement methodologies. The Hospital District is reimbursed for most services at tentative rates with final settlement determined after submission of annual cost reports by the Hospital District and audits thereof by the Medicare administrative contractor.

Medicaid. The Medicaid State Plan provides for a cost reimbursement methodology for inpatient and outpatient services rendered to beneficiaries who are not part of a Medicaid managed care network. The Hospital District is reimbursed for inpatient (excluding long-term care) and outpatient services at tentative rates with final settlement determined after submission of annual cost reports by the Hospital District with audit thereof by the Kansas Department of Health and Environment. The Hospital District is reimbursed on a prospective payment methodology for inpatient and outpatient services rendered to beneficiaries who are part of a Medicaid managed care network. Medicaid reimbursement for long-term care facility residents is based on a cost-based prospective reimbursement methodology. The Hospital District is reimbursed at a prospective rate with annual cost reports submitted to the Medicaid program. Prior to 2011, rates were computed each calendar quarter using an average of the 2005, 2006 and 2007 cost reports and changes in the Medicaid resident case mix index. As part of a provider assessment program approved by CMS on February 2, 2011, rates were updated retroactively to July 1, 2010, using 2007, 2008 and 2009 cost report data. Additional net revenues for the Hospital District relative to the provider assessment program for the period from July 1, 2010 through June 30, 2011 (the State's fiscal year), totaled approximately $102,000. Effective July 1, 2011, rates were updated using 2008, 2009 and 2010 cost report data. Rates were not rebased or inflated as of July 1, 2012. The Medicaid cost reports are subject to audit by the state and adjustments to rates can be made retroactively.

Approximately 73% and 77% of net patient service revenues are from participation in the Medicare and state-sponsored Medicaid programs for December 31, 2012 and 2011, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

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

Patient Protection and Affordable Care Act

The *Patient Protection and Affordable Care Act* (PPACA) will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

The state of Kansas has currently indicated it will not expand the Medicaid program, which may result in revenues from newly covered individuals not offsetting the Hospital District's reduced revenue from other Medicare/Medicaid programs.

The PPACA is extremely complex and may be difficult for the federal government and each state to implement. While the overall impact of the PPACA cannot currently be estimated, it is possible that it will have a negative impact on the Hospital District's net patient service revenue. Additionally, it is possible the Hospital District will experience payment delays and other operational challenges during the PPACA's implementation.

Accounts receivable are recorded net of the allowance for uncollectible accounts and allowance for contractual adjustments at December 31, 2012 and 2011, as follows:

	2012	2011
Gross patient accounts receivable		
Medicare	$ 106,184	$ 93,335
Medicaid	112,020	60,089
Blue Cross	30,962	24,618
Other third-party payers	56,791	52,394
Self-pay	450,329	430,067
	756,286	660,503
Less allowance for uncollectible accounts	(345,533)	(321,449)
Plus allowance for contractual adjustments	50,420	43,174
Patient accounts receivable, net	$ 461,173	$ 382,228

Net patient service revenue for the years ended December 31, 2012 and 2011, is as follows:

	2012	2011
Gross patient service revenue	$ 4,185,329	$ 3,070,237
Plus (less):		
Contractual adjustments		
Medicare	799,510	1,300,591
Medicaid	(26,537)	81,152
Blue Cross	(161,746)	(111,923)
Other	(59,691)	(14,473)
Administrative adjustments	(49,058)	(41,375)
Charity care	(28,560)	(35,424)
Provision for uncollectible accounts	(85,444)	(55,641)
Net patient service revenue	$ 4,573,803	$ 4,193,144

Note 4: Concentration of Credit Risk

The Hospital District grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer arrangements. The mix of accounts receivables net of allowance for uncollectible accounts and contractual allowances at December 31, 2012 and 2011, was as follows:

	2012	2011
Medicare	39%	35%
Medicaid	22	16
Blue Cross	6	4
Other third-party payers	10	15
Self-pay	23	30
	100%	100%

Note 5: Noncurrent Cash

Noncurrent cash includes 1) funds internally designated by the Board of Trustees to be used for replacement of capital assets or for the purchase of additional capital assets and 2) funds externally restricted by donors for student scholarships and loans. The internally designated funds may be used for other purposes by action of the Board of Trustees. Noncurrent cash consists of savings accounts.

The externally restricted assets totaled $12,251 and $15,868 at December 31, 2012 and 2011, respectively.

Ashland Hospital District No. 3
Notes to Financial Statements
December 31, 2012 and 2011

Note 6: Capital Assets

Capital assets activity for the years ended December 31, 2012 and 2011, was:

	2012			
	Beginning Balance	Additions	Disposals	Ending Balance
Land	$ 14,560	$ -	$ -	$ 14,560
Land improvements	41,353	-	-	41,353
Buildings	1,533,216	-	-	1,533,216
Fixed equipment	626,601	69,731	(1,236)	695,096
Moveable equipment	1,538,981	60,104	(10,777)	1,588,308
	3,754,711	129,835	(12,013)	3,872,533
Less accumulated depreciation				
Land improvements	17,355	806	-	18,161
Buildings	1,107,232	48,538	-	1,155,770
Fixed equipment	538,185	19,662	(1,236)	556,611
Moveable equipment	1,105,650	206,650	(10,777)	1,301,523
	2,768,422	275,656	(12,013)	3,032,065
Capital assets, net	$ 986,289	$ (145,821)	$ -	$ 840,468

	2011			
	Beginning Balance	Additions	Disposals	Ending Balance
Land	$ 14,560	$ -	$ -	$ 14,560
Land improvements	41,353	-	-	41,353
Buildings	1,533,216	-	-	1,533,216
Fixed equipment	626,601	-	-	626,601
Moveable equipment	1,208,612	330,369	-	1,538,981
	3,424,342	330,369	-	3,754,711
Less accumulated depreciation				
Land improvements	16,056	1,299	-	17,355
Buildings	1,057,040	50,192	-	1,107,232
Fixed equipment	522,728	15,457	-	538,185
Moveable equipment	951,440	154,210	-	1,105,650
	2,547,264	221,158	-	2,768,422
Capital assets, net	$ 877,078	$ 109,211	$ -	$ 986,289

Note 7: Long-term Debt

The following is a summary of long-term debt transactions for the years ended December 31, 2012 and 2011:

	2012				
	Beginning Balance	Additions	Deletions	Ending Balance	Amounts Due Within One Year
6% certificates of participation	$ 175,000	$ -	$ (30,000)	$ 145,000	$ 35,000
Capital lease obligations	52,381	103,647	(76,557)	79,471	54,771
	$ 227,381	$ 103,647	$ (106,557)	$ 224,471	$ 89,771

	2011				
	Beginning Balance	Additions	Deletions	Ending Balance	Amounts Due Within One Year
6% certificates of participation	$ 205,000	$ -	$ (30,000)	$ 175,000	$ 30,000
Capital lease obligations	100,594	-	(48,213)	52,381	44,147
	$ 305,594	$ -	$ (78,213)	$ 227,381	$ 74,147

Certificates of Participation

Certificates of participation, dated January 2001, in the original amount of $400,000 bear interest at 6%. The debt is payable in annual installments through February 2016. The Hospital District is required to make semi-annual interest and annual principal payments. Outstanding certificates of participation maturing February 1, 2003, and thereafter may be redeemed at the Hospital District's option.

Required annual payments on the certificates of participation as of December 31, 2012, are as follows:

Year Ending December 31,	Total to be Paid	Principal	Interest
2013	$ 42,650	$ 35,000	$ 7,650
2014	40,550	35,000	5,550
2015	38,450	35,000	3,450
2016	41,200	40,000	1,200
	$ 162,850	$ 145,000	$ 17,850

Capital Lease Obligations

The Hospital District is obligated under leases for equipment that are accounted for as capital leases. Assets under capital leases at December 31, 2012 and 2011, totaled $277,927 and $209,662, respectively, net of accumulated depreciation of $171,482 and $159,698, respectively. The following is a schedule by year of future minimum lease payments under the capital leases including interest at rates of 3.15% to 4.11% together with the present value of the future minimum lease payments as of December 31, 2012:

Year Ending December 31,		
2013	$	57,711
2014		23,614
Total minimum lease payments		81,325
Less amount representing interest		1,854
Present value of future minimum lease payments	$	79,471

Note 8: Medical Malpractice Coverage and Claims

The Hospital District purchases medical malpractice insurance under a claims-made policy on a fixed premium basis. Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate costs of the incidents. Based upon the Hospital District's claim experience, no such accrual has been made. It is reasonably possible that this estimate could change materially in the near term.

Note 9: Pension Plan

Plan Description

The Hospital District contributes to the Kansas Public Employees Retirement System (KPERS) Employee Pension Plan, a cost-sharing multiple-employer defined benefit pension plan administered by the KPERS Board of Trustees. Pension expense is recorded for the amount the Hospital District is contractually required to contribute for the year. The plan provides retirement and disability benefits, including annual cost-of-living adjustments and death benefits to plan members and their beneficiaries. The Kansas Legislature, with concurrence of the Governor, has the authority to establish and amend benefit provisions. The plan issues a publicly available financial report that includes financial statements and required supplementary information for the plan. The report may be obtained by writing to the plan at Kansas Public Employees Retirement System, 611 South Kansas, Suite 100, Topeka, Kansas 66603, or by calling 1.888.275.5737.

Funding Policy

The authority to establish and amend requirements of plan members and the Hospital is set forth by the Kansas Legislature with the concurrence of the Governor. Plan members are required to contribute 4% of their annual covered salary. The Hospital District is required to contribute at an actuarially determined rate; the rate was 7.34%, 6.74% and 6.14% of annual covered payroll for 2012, 2011 and 2010, respectively. The employer collects and remits member-employee contributions according to the provisions of Section 414(h) of the Internal Revenue Code. The Hospital District's contributions to the plan for the years ended December 31, 2012, 2011 and 2010, were $190,354, $150,958 and $118,701, respectively, equal to the statutory required contributions for each year. Contributions actually made by plan members were $128,386 and $102,466 for the years ended December 31, 2012 and 2011, respectively. State law limits the Hospital District's future contribution rate increases to a maximum of 0.6%.

Note 10: Management Agreement

The Hospital District has a management agreement with Great Plains Health Alliance, Inc. (GPHA), whereby GPHA agreed to administer operations of the Ashland Health Center and provide shared services for accounting, education and medical records. Fees incurred under the management agreement were $71,174 and $68,437 for 2012 and 2011, respectively.

Note 11: Significant Estimates and Concentrations

Allowance for Net Patient Service Revenue Adjustments

Estimates of allowances for adjustments included in net patient service revenue are described in *Notes 1* and *3*.

Current Economic Conditions

The current protracted economic decline continues to present health care providers with difficult circumstances and challenges, which in some cases have resulted in large declines in assets and contributions and constraints on liquidity and difficulty obtaining financing. The financial statements have been prepared using values and information currently available to the Hospital District.

Current economic conditions, including the rising unemployment rate, have made it difficult for certain patients to pay for services rendered. As employers make adjustments to health insurance plans or more patients become unemployed, services provided to self-pay and other payers may significantly impact net patient service revenue, which could have an adverse impact on the Hospital District's future operating results. Further, the effect of economic conditions on the government may have an adverse effect on cash flows related to the Medicare and Medicaid programs.

Given the volatility of current economic conditions, the values of assets and liabilities recorded in the financial statements could change rapidly, resulting in material future adjustments in allowances for accounts receivable that could negatively impact the Hospital District's ability to maintain sufficient liquidity.