Approved: May 7, 2008
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Dwayne Umbarger at 10:35 A.M. on February 14, 2008, in Room 123-S of the Capitol.

All members were present except:

Senator Donald Betts, Jr. - excused

Senator Jay Emler - excused

Committee staff present:

Jill Wolters, Senior Assistant, Revisor of Statutes

Alan Conroy, Director, Kansas Legislative Research Department

Kristen Clarke Kellems, Assistant Revisor of Statutes

Amy Deckard, Kansas Legislative Research Department

Audrey Dunkel, Kansas Legislative Research Department

Julian Efird, Kansas Legislative Research Department

Cody Gorges, Kansas Legislative Research Department

Aaron Klaassen, Kansas Legislative Research

Heather O'Hara, Kansas Legislative Research Department

J. G. Scott, Kansas Legislative Research Department

Jarod Waltner, Kansas Legislative Research Department

Melinda Gaul, Chief of Staff, Senate Ways & Means

Mary Shaw, Committee Assistant

Conferees appearing before the committee:

Barbara Gibson, Kansas Department of Health and Environment

Dr. Don Brada, Designated Institutional Official, WCGME

Dr. Joe Davison, West Wichita Family Physicians

Rob Freelove, M. D., Program Director, Smoky Hill Family Medicine Residency Program

Rita Buurman, CEO, Sabetha Community Hospital, Inc.

Robert Gibbs, MD, WCGME Graduate, Labette Health, Parsons

Dr. Justin Mills, Second Year WCGME, Pediatric Resident

Cindy Luxem, Executive Director, Kansas Health Care Association

Joseph Lubarsky, President, Eljay

Jim Klausman, Chair of the Board and CEO, Midwest Health Mgmt., Kansas Health Care Assn.

Steve Hatlestad, Regional Vice President, Americare Systems, Inc. Kansas Health Care Assn.

Jeff Moszeter, Eventide Convalescent Center, Kansas Health Care Association

Mike Oxford, Executive Director, Topeka Independent Living Resource Center

Alan Cobb, State Director, Americans for Prosperity Kansas

Karl Peterjohn, Executive Director, Kansas Taxpayer Network

Tom Williams, CEO, Asbury Park, Newton

Pam Bachman, Administrator, Eastridge Skilled Nursing Facility, Centralia

Tom Church, President/CEO, Catholic Care Center

Debra Harmon Zehr, President, Kansas Association of Homes and Services for the Aging

Others attending:

See attached list.

Bill Introductions

Senator Schmidt moved, with a second by Senator Wysong, to introduce a conceptual bill concerning cracking down on internet pharmacies. Motion carried on a voice vote.

Senator Kelly explained that she had a bill introduction requested by Senator Hensley regarding college textbook publishers disclosing costs to teachers for student books. <u>Senator Kelly moved</u>, with a second by <u>Senator Steineger</u>, to conceptually introduce the bill. <u>Motion carried on a voice vote</u>.

CONTINUATION SHEET

MINUTES OF THE Senate Ways and Means Committee at 10:35 A.M. on February 14, 2008, in Room 123-S of the Capitol.

Copies of the Kansas Legislative Research Department Budget Analysis report for FY 2008 and FY 2009 were available to the Committee.

Subcommittee reports:

Veterans Affairs/Soldiers' & Veterans' Home (Attachment 1)

Subcommittee Chairman Mark Taddiken reported that the subcommittee on the Veterans Affairs/Soldiers' & Veterans' Home concurs with the Governor's recommendation in FY 2008 with comment and concurs with the Governor's FY 2009 recommendation with adjustments and comments.

Copies of the FY 2009 Supplemental Requests and FY 2009 Enhancements were distributed to the Committee (Attachment 2). Senator Taddiken moved, with a second by Senator Kelly, to consider electric beds and a wheelchair lift at the Kansas Veterans' Home and VSO salaries under Veterans Services at Omnibus. Motion carried on a voice vote.

Senator Taddiken moved, with a second by Senator Teichman, to adopt the subcommittee budget report on the Veterans Affairs/Soldiers' & Veterans' Home in FY 2008 and as amended in FY 2009. Motion carried on a voice vote.

Chairman Umbarger welcomed the following individuals who gave an overview of the Wichita Center for Graduate Medical School:

Barbara Gibson, Kansas Department of Health and Environment, was present for questions and she introduced the first conferee. (No written testimony was provided). Copies of a handout were distributed titled, Doctors in Kansas, WCGME Administered Programs (Attachment 3).

Dr. Don Brada, Designated Institutional Official, The Wichita Center for Graduate Medical Education (WCGME) (Attachment 4). Dr. Brada addressed the importance of Residence Training to Kansas in that it trains new physicians for all of Kansas, including rural areas; improves quality of care; attracts quality physicians to Kansas and creates positive economic impact for Kansas. He also noted that WCGME needs an increase in State funding to replace recently reduced Medicare GME reimbursement for off-site monthly rotations and educational leave and non-clinical educational experiences.

Dr. Joe Davison, West Wichita Family Physicians, noted that family physicians go to a community and see patients (<u>Attachment 5</u>). This brings economic stimulus to a community. In his closing remarks in his written testimony, Dr. Davison indicated that closing the course of action for the state would be to close the funding gap that would allow the people of Kansas to keep their homegrown physicians at home in Kansas to meet healthcare needs.

Rob Freelove, M. D., Program Director, Smoky Hill Family Medicine Residency Program, testified that this is not just a Wichita issue, but it is a state of Kansas issue (<u>Attachment 6</u>). He noted that the immediate challenge is meeting current accreditation standards to stay open and continue providing physicians for the State of Kansas.

Rita Buurman, CEO, Sabetha Community Hospital, Inc., indicated that Sabetha is in a location in the state that should make it easy to recruit; however, that is not the case (<u>Attachment 7</u>). She noted that rural is rural and it is difficult for them to find doctors to practice in their community. Therefore, they support WCGME.

Robert Gibbs, MD, WCGME Graduate, Labette Health, Parsons, called attention to the importance of the need for specialists in rural Kansas and it cannot be overlooked because it could be life threatening if specialists are not around (<u>Attachment 8</u>). Dr. Gibbs spoke about his personal experience of the strengths of the Wichita Residency Program.

Dr. Justin Mills, Second Year WCGME, Pediatric Resident, mentioned that without adequate funding, they

CONTINUATION SHEET

MINUTES OF THE Senate Ways and Means Committee at 10:35 A.M. on February 14, 2008, in Room 123-S of the Capitol.

cannot continue to provide the current level of care to the children of Wichita (<u>Attachment 9</u>). The hospitals of Wichita are a critical part of the healthcare system in Kansas and these hospitals would not function without quality resident physicians.

The following individuals submitted written information:

Chad Austin, Vice President, Government Relations, Kansas Hospital Association (Attachment 10)

Steven Kelly, President and CEO, Newton Medical Center (Attachment 11)

Jennifer Scott Koontz, Third Year Resident, WCGME (Attachment 12)

Richard Moberly, II, M.D., Resident Physician, WCGME (Attachment 13)

John Waltner, Mayor, Hesston and Chairman, REAP Legislative Committee (Attachment 14)

Carolyn Gaughan, Executive Director, Kansas Academy of Family Physicians (Attachment 15)

Jerry Slaughter, Executive Director, Kansas Medical Society (Attachment 16)

Dr. Steen Mortensen and Dr. Denis L. Ross, Medical Society of Sedgwick County (Attachment 17)

Bob Moser, M.D., Greeley/Wallace/Hamilton County Family Practice Clinics (Attachment 18)

Gene Klingler, M.D., Manhattan Surgical Center (Attachment 19)

Office of the Dean, The University of Kansas School of Medicine, Wichita (Attachment 20)

Copies were distributed on Primary Care Physician Full-Time Equivalent (FTE) by County, 2006 KDHE Physician Survey (<u>Attachment 21</u>) and Primary Care Physician FTE Summary by County - 2006 (<u>Attachment 22</u>).

The Chairman opened the public hearing on:

SB 585--Assessments on nursing facilities; quality assurance assessment fund; initiatives for nursing care improvements

Staff briefed the committee on the bill.

The Chairman welcomed the following conferees:

Cindy Luxem, Executive Director, Kansas Health Care Association, spoke in support of **SB 585** and provided information regarding Statewide Data on Kansas Nursing Home Revenues and Expenses (<u>Attachment 23</u>) and Kansas Health Care Association **SB 585** Quality Assurance Fund (<u>Attachment 24</u>). Ms. Luxem explained that 90 percent of providers are Medicaid and this bill does not ask to have private pay residents pay a tax. Providers will pay assessment to the state and no State General Funds are used.

Joseph Lubarsky, President, Eljay, LLC, testified as a proponent on the bill (<u>Attachment 25</u>). Mr. Lubarsky noted that these funds would be used to improve facilities for those facilities that are Medicaid. He explained that under this bill the assessment would be uniformly imposed on all providers, thereby requiring no formal review or approval process with CMS.

Jim Klausman, Chair of the Board and CEO, Midwest Health Mgmt., Kansas Health Care Association, testified in support of the bill (<u>Attachment 26</u>). Mr. Klausman mentioned that this is not a tax on private pay residents of nursing facilities. The Quality Assurance Fee is paid by providers in order to allow the State of Kansas to have more federal dollars returned to Kansas to help care for frail and elderly citizens.

Steve Hatlestad, Regional Vice President, Americare Systems, Inc. Kansas Health Care Association, spoke in support of the bill (<u>Attachment 27</u>). Mr. Hatlestad explained that this is not a tax and that it would allow for future care in facilities and to bring more funds into the state.

Jeff Moszeter, Eventide Convalescent Center, Kansas Health Care Association, testified as a proponent on the bill (<u>Attachment 28</u>). Mr. Mozeter mentioned that the bill would help improve the lives of residents in facilities. He runs a small nursing home and they are 55 percent Medicaid.

Mike Oxford, Executive Director, Topeka Independent Living Resource Center, spoke in support of the bill (Attachment 29). Mr. Oxford offered an amendment (attached to his written testimony). In the proposed

CONTINUATION SHEET

MINUTES OF THE Senate Ways and Means Committee at 10:35 A.M. on February 14, 2008, in Room 123-S of the Capitol.

amendment they suggest clarifying the commitment of resources.

Alan Cobb, State Director, Americans for Prosperity Kansas, testified as an opponent on the bill (<u>Attachment 30</u>). Mr. Cobb explained that his concern is that this affects the state budget in regard to Medicaid. He encouraged a more thorough evaluation of current Medicaid programs to see what is work and what is not working before embarking on yet another program.

Karl Peterjohn, Executive Director, Kansas Taxpayer Network, spoke in opposition to the bill (<u>Attachment 31</u>). Mr. Peterjohn explained that seniors may be affected by this bill and it may drive them out of state. He noted that while this legislation is described as an assessment fee, it actually appears to be more like a tax on nursing home patients with their own private resources and Medicaid and certain other seniors would be exempt from this new tax.

Tom Williams, CEO, Asbury Park, Newton, spoke as an opponent on the bill (<u>Attachment 32</u>). Mr. Williams provided information from when Oklahoma initiated a "bed tax" in 2000. He noted that he personally saw how this tax worked when he was an adult care home administrator in Oklahoma. Mr. Williams explained how their private pay residents were very upset that they had to pay this extra cost and it also accelerated the speed of spend-down among private pay nursing residents resulting in a larger population being requiring and receiving Medicaid assistance sooner.

Pam Bachman, Administrator, Eastridge Skilled Nursing Facility, Centralia, testified as an opponent on the bill (<u>Attachment 33</u>). Ms. Bachman explained that the bill would speed up the process of depletion of many nursing home residents' private funds and a portion would have to be passed on directly to residents who are paying for their own care.

Tom Church, President/CEO, Catholic Care Center, spoke in opposition to the bill (<u>Attachment 34</u>). Mr. Church also expressed concern that this bill would greatly accelerate the depletion of private pay resident's assets. There is no guarantee of quality in the area of care.

Debra Harmon Zehr, President, Kansas Association of Homes and Services for the Aging, testified in opposition to the bill (<u>Attachment 35</u>). Ms. Zehr addressed the bill being bad public policy, would cause inflationary pressure on nursing home private pay rates, would increase the State's Medicaid obligation, and the bill is not strictly about quality.

The following conferees submitted written testimony on **SB 585**:

Steve Albrecht, Regional Director of Government Relations, Golden Living (Attachment 36)

Tom Akins, Vice President for Development and Planning, Brewster Place, Topeka (Attachment 37)

Jennifer Gillespie, Adm.CEO, Leisure Homestead Association (Attachment 38)

Jim Morford, Administrator, Good Samaritan Society, Ellsworth Village (Attachment 39)

David Randazzo, Executive Director, Claridge Court (Attachment 40)

Ryan Grace, Administrator, St. Joseph Village, Manhattan (Attachment 41)

Wade Gushee. Executive Director, Presbyterian Manor, Parsons (Attachment 42)

Jerry Ney, CEO, Aldersgate Village (Attachment 43)

Stephen Lorenzen, Ph.D., Independent Consultant, Lorenzen & Associates (Attachment 44)

The Chairman closed the public hearing on SB 585.

The meeting adjourned at 12:10 p.m. The next meeting was scheduled for February 15, 2008.

SENATE WAYS AND MEANS GUEST LIST

Date <u>February</u> 14, 2008

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NAME	REPRESENTING	
Back Coxact	KDOA	
Kary Sierle	KDOA	
JIM MORFORD	Good Samaritan & KHHSA	
Tom Church	Catholic Care Conter & KAHSA	
Debra Zeh	KAHSA	
Jon Williams	Asbury PARK - Newton Ks.	
Pam buhman	Eastnoble-Centralis 16 KAHKA	
Wade Susher	Parsons - Presbyterian Mar	nov-
TONI AKINS	BREWSTER PILLE - TOPOKA	
DAVID RANDAZZO	Claridge Court	
Bill Lee	Resident at Claridge Court	
Shari M'Cabe	The Cedars M. Pherson Ks	
DAM Daniel	KDOA	
DAVE HALFERTY	KDOA	
Don Marray	Federico Consultan	
Tracy Russell	KHPA	
Reagan Cussinario	KttpA	
Chad Austin	KHA	
Feed Linky	KHA	
DAN Morin	VS Medical Society	
MAC Austin	Eventide CONV. Center KHCH	
Phylliokely	Kaus as Adult Care Executives	
Babara Grason	KDHE	

SENATE WAYS AND MEANS GUEST LIST

NAME	REPRESENTING
STORE HATLOSTORD	KHCA
John Berelmi	PINKING SMITH; ASSOC
Jeff Moszefer	Eventude Convalescent Center
Cindy Luxer	Kansas Health Care Assoc.
Lee Eston	Alma Manor
Steve Albrecht	Golden Living
Jim Klausman	Midwest Health Management
MARK BOTTANYSK	KAHSA
MAN COBR	AFP
Gilbert ARV7	Slate LTC OMARSMAN
Had Demin	hU
M:tzi Mctatrich	Ko Advocatos for Better Care
Au. Hyten	TILRC
Kayou Hooker	Washburn Social Work
Alex Rodenbeck	Washburn Bocial Work
Effic Sumson	Senator Denck Schmidt
BRAD FREDERICK	KAHSA
Chip Wheelen	Health Care Stab' Fund
James Stocoe	KHUSH
Kail Peterjohn	Kansas Taxpayers Network
Shannon In Jones	SILCIZ
John Petersa	Cypital Stutes is
mara mamillar	KHCA

SENATE WAYS AND MEANS GUEST LIST

Date 2/14/07

NAME	REPRESENTING
RISTUMNEN	WCGME
Fenny Valsang	WC6ME
Captal Shalenes	Capital Shatagios
mary Sloan	KAHSA.
Marca Kerce	1CH CA
Kub a, hbs	WCGME
Joe Davison	WCGME
Ward Kanney	KHI
Tita Buurman	Sabetha Community Wospital, De
Kay Broda	WCGME
a Maria	е и

FY 2008 and FY 2009

SENATE WAYS AND MEANS SUBCOMMITTEE

Kansas Commission on Veterans' Affairs

Senator Mark Taddiken, Chair

Senator Laura Kelly

Senate Ways and Means 2-14-08 Attachment 1

Senate Subcommittee Report

Agency: Commission on Veterans' Affairs Bill No. SB Bill Sec.

Analyst: Gorges Analysis Pg. No. Vol.- Budget Page No.

Expenditure Summary		Agency Estimate FY 08	R	Governor's ecommendation FY 08	-	Senate Subcommittee Adjustments
Operating Expenditures:						
State General Fund	\$	9,518,191	\$	8,995,428	\$	0
Other Funds	Alexander and a second	11,302,124		10,792,951		0
Subtotal - Operating	\$	20,820,315	\$	19,788,379	\$	0
Capital Improvements:						
State General Fund	\$	0	\$	0	\$	0
Other Funds	10	9,913,791		9,913,791		0
Subtotal - Capital Improvements	\$	9,913,791	\$	9,913,791	\$	0
TOTAL	<u>\$</u>	30,734,106	<u>\$</u>	29,702,170	\$	<u>0</u>
FTE Positions		557.8		556.8		0.0
Non FTE Uncl. Perm. Pos.		0.0		0.0		0.0
TOTAL		557.8		556.8	_	0.0

Agency Estimate

The **agency** estimates current year expenditures of \$20,820,315, an increase of \$4,708,784 all funds, or 8.9 percent, above the amount approved by the 2007 Legislature. The estimate includes supplemental requests of \$658,412, all funds. Without the supplemental requests, the agency's estimate is \$20,161,903, an increase of \$1,050,372, or 5.5 percent, above the approved amount. The all funds increase reflects funds carried forward in the Soldiers' Home Fee Fund and other fee and federal funds.

The estimate includes \$9,518,191 from the State General Fund, an increase of \$785,955, or 9.0 percent above the approved amount. The increase is attributed to \$223,192 in reappropriated FY 2007 funds and \$562,763 in supplemental requests.

Governor's Recommendation

The **Governor** recommends current year operating expenditures of \$19,788,379, an increase of \$676,848, or 8.9 percent, above the amount approved by the 2007 legislature. The recommendation is \$1,031,936, or 5.0 percent, below the agency's request. Of the overall recommendation, \$240,000 would fund the recommended supplemental, and \$91,600 is added to fund equipment and services recommended by the Department of Aging Task Force for the Kansas

Soldiers' Home. The remaining increase reflects \$223,192 State General Fund moneys and \$122,056 in fee and federal funds reappropriated from FY 2007 to FY 2008.

The Governor recommends current year State General Fund expenditures of \$8,995,428, an increase of \$263,192, or 3.0 percent, above the amount of approved by the approved amount. The State General Fund recommendation is 522,763, or 5.5 percent, below the agency's current year estimate. The State General Fund recommendation is attributed to \$223,192 in reappropriated FY 2007 funds and \$40,000 for a supplemental request in the Veteran Services program for additional funding for the Emporia Veteran Service Representative (VSR) position vacant since August 2007.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the Governor's recommendation with the following comment:

1. The Senate Subcommittee notes the State General Fund increase is largely due to reappropriated FY 2007 funds carried forward to FY 2008.

Senate Subcommittee Report

Agency: Commission on Veterans' Affairs Bill No. SB Bill Sec.

Analyst: Gorges Analysis Pg. No. Vol.- Budget Page No.

Expenditure Summary	Agency Request FY 09		Governor's Recommendation FY 09		Senate Subcommittee Adjustments	
Operating Expenditures:						
State General Fund	\$	10,199,485	\$	9,437,677	\$	(1,002,206)
Other Funds	-	11,149,648		11,402,032		(2,384)
Subtotal - Operating	\$	21,349,133	\$	20,839,709	\$	(1,004,590)
Capital Improvements:						
State General Fund	\$	0	\$	0	\$	0
Other Funds		1,155,911		1,193,911		0
Subtotal - Capital Improvements	\$	1,155,911	\$	1,193,911	\$	0
TOTAL	\$	22,505,044	\$	22,033,620	\$	(1,004,590)
FTE Positions		561.8		536.8		0.0
Non FTE Uncl. Perm. Pos.		0.0		24.0		0.0
TOTAL		561.8		560.8	_	0.0

Agency Request

The **agency** requests FY 2009 operating expenditures of \$21,349,133, an increase of \$528,818, or 2.5 percent, above the revised current year estimate. The request includes \$10,199,485 from the State General Fund, an increase of \$681,294, or 7.2 percent, above the revised current year estimate. The increase is attributed to enhancements totaling \$1,883,737 which are partially offset by reductions spread throughout the agency. Without the enhancements, the request totals \$19,465,396, a decrease of \$1,354,919, or 6.5 percent, below the agency's revised current year estimate. The increase is also offset by the one-time bonus payment in FY 2008 and by funds carried forward to FY 2008 that will not be available in FY 2009.

Governor's Recommendation

The **Governor** recommends FY 2009 operating expenditures of \$20,839,709, an increase of \$1,051,330, or 5.3 percent, above the Governor's current year recommendation. The recommendation is a decrease of \$509,424, or 2.4 percent below the agency's FY 2009 request. The recommendation includes \$658,173 all funds for enhancements. The recommendation also includes \$716,140 all funds for pay plan adjustments. These increases are partially offset by the one-time bonus payment paid in FY 2008. The recommendation includes an enhancement, a shift in 24.0 FTE positions in the Kansas Soldiers' Home to non-FTE permanent positions to allow greater flexibility in filling vacant positions.

The Governor's recommendation includes State General Fund expenditures of \$9,437,677, an increase of \$442,249, or 4.9 percent, above the Governor's current year recommendation and \$761,808, or 7.5 percent, below the agency's FY 2009 request. The recommendation includes \$408,173 from the State General Fund for enhancements. The increase is partially offset by the one-time bonus payment paid in FY 2008.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the Governor's recommendation with the following adjustments and comments:

- 1. Pay Plan Adjustments. Delete \$986,890, including \$984,506 from the State General Fund, to remove the following pay plan adjustments recommended by the Governor. Pay plan adjustments will be considered in a separate bill.
 - a. **State Employee Pay Increases.** Delete \$303,911, including \$302,848 from the State General Fund, to remove the amount recommended by the Governor for the 2.5 percent base salary adjustment.
 - b. Classified Employee Pay Plan. Delete \$412,229, including \$410,908 from the State General Fund, to remove the amount recommended by the Governor for FY 2009 pay increases for basic vocational classes and for those employees identified as having the most disparity relative to market rate.
 - c. Longevity Pay. Delete \$270,750, all from the State General Fund to remove the amount recommended by the Governor for longevity bonus payments
- 2. **Vehicles.** Delete \$17,700, all from the State General Fund, recommended by the Governor as part of the agency's enhancement request for the purchase of a replacement vehicle to review at Omnibus.
- Soldiers' Home Improvements. The Senate Subcommittee notes that the Kansas Soldiers' Home is now up to date with Kansas Department on Aging (KDOA), Fire Marshall, and federal Veterans' Affairs requirements and that unclassified positions necessary to remedy KDOA deficiencies have been filled.
- 4. **Interim Study.** The Senate Subcommittee recommends an interim study on the agency's fee fund structure as it relates to the cost of operating the homes, including the pharmacy and food contracts.

FY 2009 Supplemental Requests

v	Agency Request			Gover	mendation	
Supplementals	SGF	All Funds	FTE	SGF	All Funds	FTE
Kansas Soldiers Home - Consulting Contract	\$300,000	\$300,000	0.0	\$0	\$200,000	0.0
Veteran Serivces - Emporia VSR restoration	\$60,000	\$60,000	0.0	\$0	\$40,000	0.0
Additional Equipment for Soldiers' Home	\$0	\$0	0.0	\$0	\$91,600	0.0
TOTAL	\$360,000	\$360,000	0.0	\$0	\$240,000	0.0

FY 2009 Enhancements

	Agency Request			Governor's Recommendation		
Enhancement	SGF	All Funds	FTE	SGF	All Funds	FTE
Kansas Veterans Cemetery Program	\$125,598	\$125,598	0.0	\$125,598	\$125,598	0.0
Kansas Soldiers' Home	\$929,815	\$929,815	0.0	\$0	\$250,000	(24.0)
Veteran Services - VSR in Emporia	\$41,700	\$41,700	0.0	\$40,000	\$40,000	0.0
Kansas Veterans' Home - Salaries and Wages	\$242,684	\$242,684	0.0	\$100,000	\$100,000	5.0
Kansas Veterans Home - Electric Beds	\$24,000	\$24,000	0.0	\$24,000	\$24,000	0.0
Kansas Veterans Home - Wheelchair Lift Van	\$50,000	\$50,000	0.0	\$50,000	\$50,000	0.0
Veteran Services - VSO salaries and benefits	\$50,875	\$50,875	0.0	\$50,875	\$50,875	0.0
TOTAL	\$1,464,672	\$1,464,672	0.0	\$390,473	\$640,473	(19.0)

DOCTORS IN KANSAS WCGME ADMINISTERED PROGRAMS

City	County
Abilene	Dickinson
Alma	Wabaunsee
Altamont	Labette
Andale	Sedgwick
Andover	Butler
Arkansas City	Cowley
Atchison	Atchison
Augusta	Butler
Baileyville	Nemaha
Baldwin City	Douglas
Baxter Springs	Cherokee
Belleville	Republic
Beloit	Mitchell
Bennington	Ottawa
Burdick	Morris
Burlington	Coffey
Chanute	Neosho
Clay Center	Clay
Coffeyville	Montgomery
Colby	Thomas
Concordia	Cloud
Council Grove	Morris
Derby	Sedgwick
Dodge City	Ford
El Dorado	Butler
Emporia	Lyon
Eureka	Greenwood
Fort Scott	Bourbon
Garden City	Finney
Girard	Crawford
Goodland	Sherman
Great Bend	Barton
Hays	Ellis
Herington	Dickinson
Hesston	Harvey
Hiawatha	Brown
łolcomb	Finney

City	County
Holton	Jackson
Hugoton	Stevens
Hutchinson	Reno
Independence	Montgomery
Ingalls	Gray
Junction City	Geary
Kansas City	Wyandotte
Kingman	Kingman
Kiowa	Kiowa
Lakin	Kearny
Larned	Pawnee
Lawrence	Douglas
Leawood	Johnson
Lenexa	Johnson
Liberal	Seward
Lindsborg	McPherson
Manhattan	Riley
Marion	Marion
McPherson	McPherson
Meade	Meade
Minneapolis	Ottawa
Minneola	Clark
Mission	Johnson
Moundridge	McPherson
Mulvane	Sumner
Neodesha	Wilson
Ness City	Ness
Newton	Harvey
North Newton	Harvey
Oakley	Logan
Olathe	Johnson
Onaga	Pottawatomie
Osawatomie	Miami
Overland Park	Johnson
Parsons	Labette
Peabody	Marion
Phillipsburg	Phillips

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City	County	2
Pittsburg	Crawford	かけ
Prairie Village	Johnson	6 2
Pratt	Pratt	3 C
Quinter	Gove	200 C
Rose Hill	Butler	さっさ
Russell	Russell	27 8
Şabetha	Nemaha	オーか
Salina	Saline	かなか
Scott City	Scott	
Sedan	Chautauqua	
Seneca	Nemaha	
Shawnee	Shawnee	
Shawnee Mission	Johnson	
Silver Lake	Shawnee	
Smith Center	Smith	
Soldier	Jackson	
St. Francis	Cheyenne	
Sterling	Rice	
Stilwell	Johnson	
Topeka	Shawnee]
Tribune	Greeley	
Udall	Cowley	
Ulysses	Grant	
Valley Center	Sedgwick	
WaKeeney	Trego	
Wamego	Pottawatomie	
Wellington	Sumner]
Wichita	Sedgwick	
Winfield	Cowley	

The Wichita Center for **Graduate Medical Education**

Don Brada, MD Designated Institutional Official Penny Vogelsang **Chief Operating Officer**

February 14, 2008



Wichita Center for Graduate Medical Education

> A CONSORTIUM formed to coordinate all the residencies in Wichita and Salina.



Residency **Training Programs**

- > 13 separate residency programs in Wichita and 1 in Salina
- > 272 residents
- > Receive training in all major hospitals in Wichita and Salina



- > Family Medicine Salina Via Christi
- Wesley
 > Pediatrics
- > General Internal Medicine

> Obstetrics/Gynecology

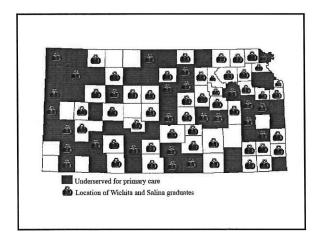
> Internal Medicine/Pediatrics

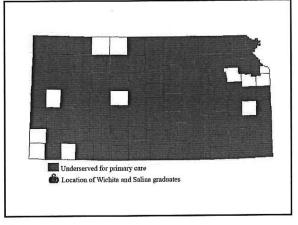


- > Anesthesiology > Orthopedic Surgery
- > Psychiatry
- > Radiology
- SurgerySports Medicine

Wichita & Salina **Residency Graduates**

- ▶Total graduates since formation of WCGME in 1989 = 1289
- ➤ Graduates last five years 349
 - 55% % who practice in Kansas =
- ➤ Primary Care graduates 209 (60%)
- last five years % in Kansas =
- 64%





The Importance of Residency Training (GME) to Kansas

- ➤ Trains new physicians for all of Kansas, including rural areas
- > Improves quality of care
- > Attracts quality physicians to Kansas
- > Creates positive economic impact for Kansas

The Importance of Residency Training (GME) to Kansas

➤ Economic impact:
Annual economic
impact of a family
physician to a
community - \$878,642



The Importance of Residency Training (GME) to Kansas

- > Over 134,000 patient visits annually to Wichita residency clinics of which 82% are Medicaid or uninsured
- > Over 27,000 patient visits annually in the Salina residency clinic of which 74% are Medicaid or uninsured

Wichita GME Expenses 2006

Resident Salaries/Benefits \$ 13,105,347
Faculty Salaries/Benefits \$ 11,735,171
Volunteer Community Faculty immeasurable
Hospital Residency Clinic Expenses \$ 12,422,549
Other Operating Expenses \$ 10,695,271
Total \$ 47,958,338

Wichita GME Revenue Sources 2006

Medicare GME Funding through

Wesley and Via Christi \$ 27,231,982
Hospital Residency Clinic Revenue \$ 9,803,789
Medicaid GME Funding \$ 4,945,751
State Primary Care Support \$ 2,643,275
Grant Funding \$ 16,884
WCGME Operating Shortfall Subsidized by Wesley and Via Christi \$ 3,316,657
Total \$ 47,958,338

Accreditation Challenges:

To maintain accreditation and quality programs in Wichita and Salina, two funding issues must be addressed:

- > The Accreditation mandates
- » Reduced Medicare GME funding

The Accreditation Council for Graduate Medical Education (ACGME) has changed accreditation standards by mandating paid time for faculty research, teaching and administration.

Mandated Paid Time for Faculty

- **≻**Administration
 - Training Directors
- ➤Teaching
 - Increasing requirements for didactic lectures, journal clubs, specific topics
- > Research

ACGME Citations or Concerns

Of our fourteen programs, seven have been cited or warned for inadequate research and scholarly activity.

Faculty and residents - 3

Residents

_ 2

Faculty

- 2

ACGME Citations or Concerns

"The institution provides inadequate resources and support for resident scholarly activity."

"There is inadequate scholarly activity by the faculty."

"There is little evidence that residents are actually involved in research and scholarly activity."

ACGME Citations or Concerns

"[The committee] identified two areas for your ongoing attention: 1.Program support for resident and faculty scholarly activity, some of which results in peer-reviewed publications and/or presentations, must be emphasized."

"The following areas must be improved at the time of the next site visit. Both program director and faculty should document improved scholarly activity."

Research

- > A spectrum from basic to applied from the test tube to clinical practice
- > We are not proposing an investment in buildings or equipment We need people
- My predecessor put it best ... "There is plenty of clinical material here in Wichita; however there are limited role models to help the residents do research."
- We're asking for an investment in those role models or teachers.

To meet our accreditation needs:

WCGME needs State funding for additional paid faculty and an infrastructure for research in Wichita and Salina.

Estimated cost - \$6,752,054

WCGME also needs an increase in State funding to replace recently reduced Medicare GME reimbursement for:

- > Off-site monthly rotations
- > Educational leave and non-clinical educational experiences
- > Projected Medicare GME lost revenue \$1,739,292

NEED

New Funds Needed to Meet ACGME Requirements

\$6,752,054

Funding for non-covered rotations and leave

1,739,292

Current Shortfall

3,316,657

Increase residents numbers by 10

650,000

Total

\$12,458,003

WCGME is requesting that the State invest in training physicians for the benefit of the citizens throughout the state.



WEST WICHITA FAMILY PHYSICIANS, P.A.

Kirk R. Bliss, D.O.
Joe D. Davison, M.D.
Larry A. Derksen, D.O.
Rick W. Friesen, M.D.
Robert Gonzalez, M.D.
Kris L. Goodnight, M.D.

Rebecca L. Green, M.D. Mark A. Hilger, M.D. D. Scott Kardatzke, M.D. Kimberly D. Kenas, D.O. David K. Lauer, M.D. William C. Loewen, M.D. Michael G. Ludlow, M.D. Stan A. Messner, M.D. Todd A. Miller, M.D. Tobie R. Morrow, D.O. Ronald J. Reichenberger, M.D. Gary W. Reiswig, M.D. Jeffrey S. Reiswig, M.D. David A. Robl, M.D. Edward J. Weippert, M.D. Yao Y. Yang, M.D.

Submitted by: Dr. Joe Davison Address: 8200 W. Central

8200 W. Central Wichita, Ks 67212

Submitted to: Members of the Kansas State Legislature

I appreciate this opportunity to express my support for the funding request of the Wichita Center for Graduate Medical Education (WCGME). WCGME is the organization formed by the University of Kansas School of Medicine-Wichita and hospitals to share joint responsibility for graduate medical education. They are responsible for the training of more than 1,289 physicians since their inception with 55% of these doctors currently practicing in our state. Despite this outstanding record of training and placing physicians in the state of Kansas, there continues to be a great need within our state for primary care physicians. The Kansas Physician Workforce Report clearly shows that Kansas is below the national average for physicians per 100,0000 population.

As a past President of the Kansas Academy of Family Physicians and a volunteer physician- teacher, I am strongly aware of this critical healthcare problem. KAFP has long worked to promote rural medicine and advocate for family medicine throughout Kansas. As a practicing physician, I have faced patients who must endure incredible hardship because of poor access to medical care. These hardships have directly affected their well being. Kansas's rural health dilemma is not unique, but it is a crisis! WCGME and its medical residency programs in the Wichita area and Salina are essential to meeting needs. The irony of this is that the Kansas University School of Medicine-Wichita through WCGME has an outstanding record of training and placing primary care physicians in our state. This record has been achieved by several factors:

*First, the Wichita branch of KU School of Medicine was originally founded to prepare physicians for clinical practice. This is not to say that research is being neglected in Wichita, but more correctly the original intent was for the "hands on" training of physicians for a medical practice.

*Second, WCGME coordinates 13 separate residency programs and one in Salina. Over 270 residents receive their training in all the major hospitals. In addition, we have three nationally recognized family medicine residencies with an excellent track record of training and retaining family physicians for our state.

Senate ways and means 2-14-08 Attachment 5 *Third, we have outstanding medical education environment supported by the entire community. The medical residency programs include a large number of volunteer physician-teachers. It is clear that the administration is directly responsible for their success.

The Wichita branch of KU School of Medicine is having a financial crisis. The federal government has always been a major funder for medical education, but over the past several years, the portion of funding supported by the federal government has dropped dramatically. This situation is not unique for Kansas, but unfortunately the cost of training a family medicine physician is one of the highest of all specialties. As I just mentioned, it is a major focus of the Wichita branch of the School of Medicine and a separate line-item for WCGME is needed.

In addition to the funding crisis, the national accrediting agency for graduate medical education has expanded its requirements. They have mandated a requirement for scholarly research in order to maintain accreditation. This new accreditation requirement will need to be implemented in the training programs.

Let me close by summarizing my concerns. Kansas is a rural state and like many rural states, it has a healthcare workforce shortage. This frequently is addressed as a rural access problem, but clearly this could include any area that has a healthcare access problem including inner cities. Through the success of KU School of Medicine and specifically the Wichita branch, our state has a wonderful opportunity to rectify this crisis. Unfortunately, the cost of training the very physicians needed the most is high and the federal funding has decreased.

A logical course of action for the state would be to close the funding gap of the Wichita Branch of KU School of Medicine through WCGME. This will insure efficient utilization of taxpayer dollars for the continued success of all of our nationally-recognized primary care physician training programs. Ultimately, it will allow the people of Kansas to keep our homegrown physicians at home in Kansas meeting the healthcare needs of Kansas.

Sincerely

Joe D. Davison, M.D.

West Wichita Family Physicians



Salina Health Education Foundation

Smoky Hill Family Medicine Residency Program

651 E. Prescott Salina, Kansas 67401

Phone (785)825-7251

Facsimile (785)825-1605

Residency Email cbachman@salinahealth.org

Robert Freelove, M.D. Program Director

Robert Kraft, M.D. Associate Director

C. Scott Owings, M.D. Associate Director

Charles Allred, M.D. Associate Director

Caren Bachman Residency Coordinator February 14, 2008

Members of the Legislature:

Thank you for allowing me to share my perspective and voice my support for the request for funding being made by the Wichita Center for Graduate Medical Education (WCGME). I am currently the Program Director of the University of Kansas School of Medicine – Wichita Family Medicine Residency Program at Smoky Hill in Salina (Smoky Hill). Smoky Hill's relationship to WCGME is through our affiliation with the University. As a result of that affiliation, WCGME provides administrative oversight for continued accreditation.

Smoky Hill first opened in 1979 as a result of a State legislative mandate in 1977. Since that time, we have graduated 92 family physicians with 71 practicing in Kansas and 67 practicing in non-urban settings in Kansas. We have the highest percentage of graduates staying in Kansas to practice Family Medicine, and the highest percentage of graduates practicing rural Family Medicine in the nation. We have experienced much success, and yet we are still on the verge of a crisis.

Impending cuts in Medicare reimbursement forces our teaching hospitals to tighten their belts. Federal funding specifically for graduate medical education is threatened with stays or cuts every year; not only the funding through Medicare, but also federal grant programs that many residencies could not operate without.

Making matters worse, residency programs are limited in their ability to generate clinical revenue. Faculty can not see patients continuously to generate their salaries and still provide required teaching and supervision functions. Recently, the Accreditation Council for Graduate Medical Education (ACGME) enacted new accreditation standards requiring more faculty time be devoted to scholarly activity, research and administration; all things that have not only a fiscal note, but also a time requirement that removes faculty from teaching and seeing patients.

In addition, the face of medicine is changing and residency education must change with it. Recently, the Department of Family and Community Medicine at Wichita and each of the three WCGME Family Medicine residency programs met collaboratively with a consultant to re-evaluate not only what but also how we are teaching our residents and future doctors for the State of Kansas. This effort culminated in several recommendations for the Department and the residency programs; including practice redesign, electronic health record implementation, adding faculty to meet additional accreditation requirements, and developing centers for research support and faculty development. All of these elements are crucial to maintaining our position as one of the best places in the nation for training Family Physicians.

All of this impacts the state of Kansas in two ways. The more immediate challenge is meeting current accreditation standards to stay open and continue providing physicians for the State of Kansas. The long term challenge is making sure those physicians have been well trained to practice today's and tomorrow's medicine. The funding requested by WCGME will help us to overcome those challenges. Thank you for your time and your careful consideration.

Sincerely,

Rob Freelove, MD Program Director

Smoky Hill Family Medicine Residency Program

Senate Ways and Means 2-14-08 Attachment 6 Abilene Alma

Arkansas City Atchison Burlington Clay Center

Concordia

Council Grove

Eureka
Fort Scott
Garden City
Goodland

Greensburg

Hays

Hiawatha

Holton

Junction City

Lakin

Lindsborg

Manhattan

McPherson

Ness City

Newton

Oalslass

Oakley

Oberlin

Olathe

Phillipsburg

Quinter

Sabetha

Salina

Seneca

Smith Center

Sterling

St. Francis

Tribune

Wamego

Wichita

Ulysses

Sabetha, KS 66534



To Members of the 2008 Legislature

Please allow me to offer this written comment of support for the Wichita Center for Graduate Medical Education (WCGME).

I have served as the CEO at the Sabetha Community Hospital, located in NE Kansas for 29 years. Over that period of time physician recruitment and retention has always been on my list of major concerns.

We have a hospital owned, hospital based practice at this time with five employed Family Practice physicians. The most recent recruit joined our practice in August, 2007. The practice is now fully staffed, but it has taken years to reach this point. We now can offer our young Doctors the quality of life they are looking for in relationship to the call issue, as well as the knowledge support they feel in a multiple Physician practice.

All of our Physicians are American Academy members and Trauma Certified, which allows them to provide top notch primary care to our community. All 5 of them are native Kansans, 4 of 5 did undergrad at KSU, and all attended Medical school in Wichita or Kansas City. One of our physicians was a Smoky Hills Salina program Resident.

Four of five of our Doctors did Residencies out of state, but while out of state we remained in contact with them as part of our ongoing recruitment process, and were able to entice them to return to Kansas. Without the solid relationships they built in Medical school, that recruitment would not have been possible.

I understand the financial situation the legislature has to consider as they look at funding for this program, but I do think it does require everyone to look at the long term implications if the program is not funded.

We are in a location in the State that should make it easy to recruit. We are 90 miles from Kansas City and a Metro airport, 60 miles from Topeka, 58 miles from St. Joseph, Mo., 110 miles from Omaha, Nebraska. However, that is not the case. Rural is rural, and if we find difficulty in finding doctors to practice in our community, I can only venture to guess the hardship for those communities west of Hiway 81.

P.O. Box 229 • Sabetha, KS 66534 • (785) 284-2121 • Fax (785) 284-2516 www.sabethahospital.com

Senate Ways and Means 2-14-08 Access to primary care is a problem nationally, but in my estimation, if we allow the Wichita program to close its doors, we in Kansas outside of the metro areas will be in crisss.

We are fortunate to have several large employers in our small community. In fact, there are more paychecks written than the population of the town itself. The draw for labor is obviously from around the region. This does contribute to economic development for this region and ultimately the State. This growth and development would not continue if healthcare were not of good quality and available locally.

I ask that you consider the access for all Kansans in the future. The program in Wichita as one of my Doctors said to me this morning "is the real future of rural healthcare in Kansas." We all join in asking your continued support the Wichita Center for Graduate Medical Education.

Respectfully,

Rita Buurman, CEO Sabetha Community hospital,Inc. PO Box 229 Sabetha, KS 66534

rbuurman@sabethahospital.com 785-284-2121- Ext. 521



1. Robert Gibbs, MD

2. Biographical information Hometown: Coffeyville, KS

College: KU

Medical School: KUMC - last 2 years in Wichita Residency: Diagnostic Radiology - UKSM-Wichita

Current Position: Solo, private practice Radiology in Parsons, KS

3. Wife - Vicki Rawdon, MD - Pediatrics Spent many years in Kansas City

- 4. Personal experience of the strengths of the Wichita Residency Programs
- 5. View of the Wichita Residency Programs as a physician in practice in rural Kansas.
- 6. Importance of need for specialists in rural Kansas can't be overlooked.
- 7. Example of the Radiologist outlook for Southeast Kansas

I come to you as one of the 250+ medical residents working and learning through the WCGME programs. I am also proud to be a 4th generation Kansan. My mother was born and raised in Kansas City, KS. My father came here from Washington, D.C. to attend medical school and has maintained a practice in Lansing for the last 27 years. I am myself a graduate of Lansing High School. I hold both a bachelor and medical degree from the University of Kansas and served as Student Body President at KU in 2001-2002. During medical school I completed my clinical training in Wichita. After graduation I took a position as a pediatric resident though the WCGME program. Currently I am in my second year of residency.

I have come here today to speak with you about an issue that is of the utmost importance to myself, my fellow residents in Wichita, and I believe, the healthcare of many Kansans. Due to new requirements and cutbacks in healthcare spending, WCGME faces a budget shortfall of close to \$9 million with a projected need of up to \$13 million in the next two years. I know that this is a tight budget year and we are asking for a considerable amount of money. But, it is my belief that funding our organization is, and should be, a priority for the State of Kansas this year.

In the last few weeks you have heard testimony from two other residents, Richard Moberly and Jennifer Koontz. They both talked to you about their experiences, the structuring of medical residency and their reasons for choosing a WCGME residency. Today I would like to speak about the importance of resident education in the healthcare system. It is important to remember that not only do WCGME programs provide training to the residents in Wichita, but they also provide a valuable service to the people of Wichita and to a large portion of Kansas. I believe the Pediatrics program demonstrates this well.

The residents in our program staff the Wesley Pediatrics Clinic. Each day our clinic sees between 50-80 patients and does nearly 500 well-child exams each month. In our clinic the overwhelming majority of our patients are low-income families whose children receive some form of state assistance. While I believe that we provide excellent care and employ the most current pediatric knowledge, I know that many of our patients come to our clinic because they simply have no place else to receive healthcare. This is mainly because nearly all other Wichita pediatrics clinics will only see limited numbers of Medicaid patients or refuse to see these patients altogether. Additionally, as "safety net" clinics in the community close and as more physicians cap or refuse Medicaid patients, our clinic is forced to absorb this population. Because of this, the need for our clinic in this community is greater than it has ever been.

Without adequate funding I feel that we cannot continue to provide the current level of care to the children of Wichita. Additionally, our general pediatrics service, Neonatal ICU and Pediatric ICU serve not only the Wichita area, but also large parts of Kansas. On any given day I may take care of patients from Liberal, Quinter, Salina or Arkansas City. The hospitals of Wichita are a critical part of the health care system in Kansas and these hospitals would not function without quality resident physicians.

The residents that graduate from this program come away with quality training and a good understanding of both urban and rural medicine. Many of the graduates of my program plan on starting or joining practices in Kansas now or after finishing further studies. For myself, I am planning on returning to school to earn a Masters in Public Health. My hope is to teach health policy and pediatrics to future medical students at my alma mater, The University of Kansas.

Resident medical education plays a significant role in the Kansas health care system. I cannot stress enough that the failure of the legislature to act on this issue will have dramatic and long-term affects on the health of many Kansans.

Let me leave you with one thought. The strength of any community is based on the health of its people. I think the committee will agree that quality healthcare should be a priority for the people of Kansas. Please help us to continue to provide the quality that Kansans have grown to depend on.

Sincerely,

Justin A. Mills, M.D. Pediatrics PGY-2 5623 E. 49th St. North Bel Aire, KS 67220

Senate Ways and Means 2-14-08 Attachment 9



Thomas L. Bell President

February 14, 2008

To:

Members of the Kansas Legislature

From:

Chad Austin

Vice President, Government Relations

Subject:

Wichita Center for Graduate Medical Education Funding

The Kansas Hospital Association expresses our support for the Wichita Center for Graduate Medical Education program that provides residency training for physicians in Wichita and Salina (Smokey Hills Residency program). These programs have played a pivotal role in the preparation and training of numerous primary care physicians across the entire State of Kansas.

Across the nation and in Kansas, urban and rural communities continue to experience difficulty recruiting and retaining physicians. As reported in 2007 by the U.S. Department of Health and Human Services, more than 80 Kansas counties are designated with some type of health professional shortage area. The challenge to recruit and retain physicians in Kansas does not appear to show any signs of relief in the foreseeable future. Kansas is fortunate to have very successful and thriving graduate medical education programs. Nearly 1,300 residents have graduated from the program in Wichita and Salina since its inception in 1989 and over 50% of the graduates within the past five years have remained in Kansas. Thus, supporting these vibrant programs will only benefit Kansas more since these trained physicians are more likely to stay in Kansas.

The future responsibility of maintaining an adequate supply of physicians in Kansas should be a responsibility of the entire state. The Wichita Center for Graduate Medical Education deserves the necessary financial support to continue its efforts to train as many physicians as possible for Kansas. It is difficult to imagine the statewide health care crisis that would develop if the Wichita Center for Graduate Medical Education program was diminished, or worst yet closed.

The Kansas health care system depends on the availability of properly educated and trained physicians. KHA and its members urge the Legislature to provide the needed financial support to the Wichita Center for Graduate Medical Education.

To Members of the 2008 Legislature:

Thank you for the opportunity to urge your support for the Wichita Center for Graduate Medical Education (WCGME).

I have served as a CEO of hospitals for more than twenty years with most of those dedicated to community and rural hospitals. One of the challenges that are faced in meeting community health care needs is the availability of qualified physicians of all disciplines, but especially those in Family Practice. The Wichita Center for Graduate Medical Education has been essential in meeting these challenges and making sure that quality health care is accessible and available to all Kansans. Understanding the difficulty in physician recruitment, I shutter to think of the number of areas in the southern and western part of our state who would possibly not have a physician had it not been for the WCGME program.

At Newton Medical Center in Newton Kansas, we have been blessed as the recipient of many physicians educated through the Wichita program. Not only are these excellent health care providers, but many are Kansans who are a natural match for our area. Without the Wichita program, I am confident that we would not have the quality medical staff that we currently enjoy.

Many studies predict physician shortages in the future. Kansans should not experience many of these problems because of the forward thinking our state has had in the development of the Wichita Center for Medical Education. Now is not the time to undercut a program that has more than met its goals and promises to continue to be essential in meeting the medical needs of Kansans.

Thanking you for your leadership,

Steven G. Kelly, DHA, FACHE

President & CEO

Newton Medical Center

Newton, KS



MERCY HEALTH SYSTEM OF KANSAS

February 4, 2008

To Members of the 2008 Legislature

As CEO of two rural Kansas hospitals I offer support for the Wichita Center for Graduate Medical Education (WCGME).

Mercy Health System of Kansas is located in southeast Kansas with hospitals in Fort Scott and Independence. Currently out hospital based physician group employs 31 physicians with full practices and recruitment is underway for additional coverage in family practice, internal medicine, orthopedic and cardiology services to meet the needs of our communities.

Recruitment of physicians to a rural area is a difficult and costly project and one that will be made even more difficult if funding for training is cut. The shortage of physicians affects basic healthcare access for rural communities, when there simply are not enough physicians to provide care.

WCGME has an established success rate in providing physicians for Kansas. Please consider the impact on thousands of Kansans if the number of physicians continues to decline. The future of rural Kansas healthcare is being decided today and your support for WCGME will be a positive step in assuring our communities have this basic healthcare access.

Respectfully,

John T. Woodrich President/CEO



February 4, 2008

Senator Stephen Morris State Capitol 300 SW 10th Room 371E Topeka, Kansas 66612-1704

Dear Senator Morris,

Please allow us to offer this written consent of support for the Wichita Center for

Graduate Medical Education (WCGME).

The WCGME is not a Wichita issue but a Kansas issue. Many rural parts of Kansas benefit from the program because they are able to recruit WCGME trained physicians. Without the WCGME trained physicians, the pool of available physicians would be much smaller thus making it nearly impossible to recruit physicians to rural Kansas. More than 70% of Kansas counties depend on physicians who graduated from the WCGME.

All of our physicians are Trauma Certified and members of their respective national academy, which allows them to provide quality primary care to our community.

Two of five of our physicians attended Medical School in Kansas City. Two of

our physicians were Smoky Hill Salina Program Residents.

We understand the financial situation the legislation has to consider as they look at funding for this program, but we do think it does require everyone to look at the long

term implications if the program is not funded.

Access to primary care is a problem nationally, but in our estimation, if we allow the Wichita Program to close its doors, we in Kansas outside of the metro areas will be in crisis. Our State's ability to recruit and train new physicians is very important to the quality of care available to Kansans.

We ask that you consider the access to care for Resident's in Southwest Kansas. We are asking your continued support for the Wichita Center for Graduate Medical

Education.

Respectfully,

Robert Ohlen

Chief Executive Officer

Mike Brewer

Hine Burn

President



February 6, 2008

The Honorable Senator Jay Emler Kansas State Senate State Capitol 300 SW 10th Street Topeka, KS 66612-1504

Dear Senator Emler:

I am writing to request your support for the Wichita Center for Graduate Medical Education and to vote in favor of fully funding the WCGME program in 2008. It is vitally important a continuing pool of newly trained Kansas physicians be available to Kansas communities and especially rural communities. Data from the Kansas Hospital Association reveals more than seventy percent (70%) of Kansas counties depend on physicians who graduated from the Wichita Center for Graduate Medical Education.

Support for this program is obviously not a Wichita issue. Without WCGME trained physicians, the pool of available physicians would be much smaller and would certainly make it even more difficult than it already is to recruit physicians for our clinics and hospitals. Thank you for your support.

Sincerely,

W. Charles Waters
President & CEO

250 WEST NINTH • HOISINGTON, KANSAS 67544 620-653-2114



200 COMMODORE

February 1, 2008

Senator Ruth Teichman 434 E. Old Hwy. 50 Stafford, KS 67578

Dear Senator Feichman:

I am writing this letter requesting your support to fully fund the Wichita Center for Graduate Medical Education. As you know, this request is for \$9.6 million in funding in 2008 which is a lot of money, but the long-term ramifications of not fully funding WCGME could mean limiting or possibly even the closure of the program, which would be devastating for Kansas hospitals and communities. More than 70% of Kansas counties depend on physicians who graduated from the Wichita Center for Graduate Medical Education. Pratt Regional Medical Center absolutely depends on WCGME. Four of the last six physicians we have recruited to PRMC came from either the Smoky Hills residency program or the Wichita program. Eighty-two percent of our active medical staff obtained their medical degree from the University of Kansas.

Physician and professional staff recruitment and retention is my number 1 strategic initiative and has been for many years. We have found that over the years, physicians from this state/region are much more likely to stay long-term. Being successful with this initiative is in large part directly due to WCGME and the great medical school we have in Kansas. WCGME is NOT a Wichita issue - it is a KANSAS issue. Thanks Senator for your consideration of this very important matter!

Susan Page

President and CEO

Pratt Regional Medical Center



To:

Senate Ways and Members Committee

From:

William K. Mahoney, CEO

Labette Health

Re:

Wichita Center for Graduate Medical Education

Date:

February 4, 2008

Labette Health is a 109 bed rural hospital located in Parsons, KS. We are one of the top employers in Southeast Kansas with 465 full time employees and a payroll of over 18 million dollars per year.

The ability of our hospital to positively operate and offer high quality healthcare depends highly on our ability to recruit in needed physicians. Rural Kansas as you may know already struggles with recruiting in physicians.

A good share of the physicians we recruit into our area come from the Wichita Graduate Medical Education program. Without this feeder program, we would be unable to have enough physicians to meet the need of the communities we serve.

I urge you to adequately fund the Wichita Center for Graduate Medical Education. If you have any questions I can be reached at 620-820-5372 or wmahoney@labettehealth.com.

Respectfully,

William K. Mahoney, CEO

Labette Health



Medicine Lodge Memorial Hospital

710 North Walnut Medicine Lodge, Kansas 67104 (620) 886-3771

Kevin A. White Administrator

February 1, 2008

To: Senate Ways & Means Committee

From: Kevin A. White, Administrator

Medicine Lodge Memorial Hospital

710 N. Walnut

Medicine Lodge, KS 67104

Re: Wichita Center for Graduate Medical Education

I am writing this letter to you in support of the Wichita Center for Graduate Medical Education. I believe that it is imperative that the WCGME is funded fully. Having graduate medical education in Wichita is absolutely necessary if we are going to be able to recruit and retain physicians in rural Kansas. Expanding and improving the WCGME program will be a very large step in improving the physician shortage issue, without the program it will be nearly impossible to meet the physician needs in rural Kansas.

I appreciate your help on this serious matter.

Sincerely,

Kevin A. White, Administrator

von ballete

Jewell County Hospital Mankato, Kansas 66956

To: Members of the Kansas Legislature

From: Doyle L. McKimmy, FACHE

CEO, Jewell County Hospital

Re: Wichita Center for Graduate Medical Education

I am writing to express my deep concern related to the potential of the Wichita Center not receiving "full funding". As the CEO of a rural CAH facility with no permanent physician at this time, I know first hand how difficult it is to find let alone attract a physician to this area. The Wichita Center has been a wonderful source of leads and we need this valued program to be fully funded.

I would ask that you emphasis to the Senate Ways and Means Committee members that rural is clearly different from the metropolitan practice of health care where many physicians are available. This is a Kansas issue, not a Wichita issue. If all of the Committee members could "live in my shoes" for a month, they would gain a quick idea of how difficult it is on the physician recruiting side as well as the reimbursement side. Having been in large health systems in Michigan, this job is by far the most challenging that I have experienced due to the afore mentioned sentence.

Again, I am advocating full funding support for this program.

Sincerely,

Doyle L. McKimmy, FACHE

Dear Members of the 2008 Kansas Legislative Session:

My name is Jennifer Koontz, MD and I am a 3rd-year resident in family medicine in Wichita. I grew up in Hutchinson, attended college in Newton and went to medical school at the University of Kansas. I am writing to you today to explain the important impact that medical education in Wichita has had in my life and why I feel it is critical to the well-being of Kansas. Through support from the Wichita Center for Graduate Medical Education (WCGME), I have become well-versed and prepared to be an effective physician for the state of Kansas.

My first exposure to medical education in Wichita came during my 3rd and 4th years of medical school during my clinical rotations. The community hospitals in Wichita have a strong reputation of providing a robust hands-on experience for medical students and I enjoyed learning clinical medicine in this environment. The residents and attending physicians in Wichita were strong role models for me as I developed into a physician and decided to pursue a career in family medicine. When it was time for me to choose a residency, I needed to look no further than Wichita, which has arguably the best family medicine residency in the country.

The Wichita area provides a fertile training ground for obstetrics, adult medicine, pediatrics, surgery, and endoscopy. I feel quite fortunate that state-of-the-art training is provided in my home state, not more than an hour from my family and the town where I was raised. Because staying in Kansas to work as a physician has always been my goal, training in my home state has proven rewarding. I have had the opportunity to do rotations in both Salina and Manhattan, which have introduced me to new parts of our state. I have also been able to get to know the vast network of specialists in the central Kansas area, have been able to be involved in our specialty's state academy, and have spent much time working in rural Kansas while getting to know primary care doctors across the state.

There are three important ways that Wichita residents contribute to the state of Kansas that I would like to highlight today. First, residents are more likely to find jobs near where they did their residency training. It is very important that we continue to support and expand residency training in Wichita and Salina so we can continue to supply Kansas with an adequate number of physicians. Residents from Wichita training programs currently work across the state in over 75 communities, from Colby and Tribune to Belleville and Chanute.

Second, residents provide indigent care to a vast number of patients. At my family medicine residency clinic, we see greater than 70% Medicaid patients and many uninsured. We also have regular clinics to provide general and obstetrical care at three local indigent clinics. All of the residency programs have similar clinics and we also take care of all hospital patients who do not have a regular doctor or are uninsured. Residents have taken care of this population for years and will continue to do so.

The last point I would like to highlight is our role in providing medical care to rural Kansas. More than 90% of our resident physicians work in rural communities during nights and weekends to offer relief to the local physicians who are serving those communities. I have worked in Onaga, Marion, Harper, McPherson, Eureka, and Wellington. Other communities that our residents serve include Lakin, Plainville, Medicine Lodge, Russell, Lindsborg, and Council Grove. In total, the resident physicians work in more than 60 different counties across the state of Kansas.

In summary, I am proud to say that the state of Kansas has provided my medical education for me. I take great pride in our state and look forward to a long career of helping support the health of our communities. I firmly believe that supporting graduate medical education in central Kansas is a worthwhile cause that will continue to benefit the state of Kansas for years to come.

Sincerely,

Jennifer Scott Koontz, MD, MPH 5903 E. Parkview Drive Park City, KS 67219 jkoontz@kumc.edu

> Senate Ways and Means 2-14-08 Attachment 12

Dear Kansas Legislators:

My name is Rick Moberly, and I am a resident physician at the Wichita Center for Graduate Medical Education (WCGME). I was raised in a small town in Colorado. I earned a bachelor's degree in biology from Wichita State University. Next, I graduated from medical school at the University of Kansas.

After medical students graduate from 4 years of medical school, they are conferred the title of doctor. These new doctors now must choose a specialty and decide where they would like to go to residency for the next three to five years. This is often a difficult decision to make. Residencies, like medical schools, are not all created equal.

There are two basic types of residencies. The first is what is commonly called an "academic" program. Residents who choose this type of residency usually have a desire for further training beyond initial residency training into programs called fellowships. Fellows go on to be sub-specialists like cardiologists and plastic surgeons. Residents training at academic programs often work closely with fellows and have less contact with the attending physicians. Often, the more complicated cases are handled by the fellows and not necessarily by the residents. However, residents at academic centers usually have more opportunities to be involved in research. Having research experience is beneficial when applying to fellowship programs.

The second type of residency is referred to as a "community" program. Residents who choose to go to community programs are less concerned with becoming specialists and more often become primary care physicians. Fellows are usually rare or not present in community programs. Residents learn directly from the attending physicians; this results in better hands on experience. Community programs often rely on volunteer physicians to teach the residents. Volunteer physicians have less time available to devote to research than paid faculty at academic residencies.

When I graduated medical school from KU, I knew that I wanted to be a family physician. I also want to eventually practice in a rural area, so a community based residency with a lot of hands on experience is very important to me. My clinical training in medical school was based at the Wichita branch of KU School of Medicine. I was very familiar with the quality of training at WCGME. However, I am also from Colorado and I wanted a residency program in closer proximity to a ski slope. I interviewed in many community based programs in Colorado. The grass was not greener in Colorado.

The residencies at WCGME have a great reputation across the country. I took for granted the training available at WCGME programs, but I soon realized what we have in Wichita is special. WCGME trained physicians are trained to be autonomous in rural communities. They also have the advantage of seeing difficult and rare medical cases because of the size of Wichita hospitals. This create a unique learning environment that is unparalleled in the country.

Although my plans for skiing failed, I am completely satisfied with my training here in Wichita. In one day, I can care for a sick child, save a man with a heart attack, and deliver a baby. WCGME is one of the shining jewels of Kansas and needs to be protected. Forty years from now when I retire in western Kansas, I want to hand my practice over to a graduate of WCGME, because I know exactly what I'll get.

Thank you for your time,

Richard W. Moberly II MD 505 N Rock Road, Apt 1037 Wichita, KS 67206 rmoberly@kumc.edu



ANDOVER, ARKANSAS CITY, AUGUSTA, BEL AIRE, BENTLEY, BENTON, BUTLER COUNTY, CHENEY, CLEARWATER, COLWICH, CONWAY SPRINGS, DERBY, EL DORADO, HALSTEAD, HARVEY COUNTY, HAYSVILLE, HESSTON, HUTCHINSON, KECHI, KINGMAN COUNTY, MAIZE, MCPHERSON COUNTY, MULVANE, NEWTON, PARK CITY, RENO COUNTY, ROSE HILL, SEDGWICK, SEDGWICK COUNTY, SUMNER COUNTY, VALLEY CENTER, WELLINGTON, WICHITA, WINFIELD

Date: February 14, 2008

From: John Waltner, Mayor of Hesston and Chairman of the REAP Legislative

Committee

Good morning, my name is John Waltner, I am the Mayor of Hesston and chair the Legislative Committee of the Regional Economic Area Partnership. Thank you for allowing me to submit testimony in support of funding for the Wichita Center for Graduate Medical Education on behalf of REAP.

REAP is a coalition of 34 cities and counties in South Central Kansas, formed in 1997 to work together on issues of common concern. Our mission is to help guide state and national actions that affect economic development in the region, and to adopt joint actions among member governments that enhance the regional economy.

REAP recognizes the importance to recruit, train and place physicians in Kansas and the positive impact on the economy in South Central Kansas, as well as the state as a whole. The region is in need of educated physicians to provide quality health care services that help to promote and foster economic activity.

Over 60 percent of the physicians practicing in south central Kansas received some or all of their training through the now WCGME administered residency programs. In fact, without this program and the residencies the majority of the counties in Kansas including the south central region would be underserved for primary care.

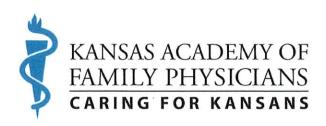
In addition, the WCGME program has a direct economic impact of over \$48 million in South Central Kansas. Studies show that family physicians are significant generators of economic activity in local communities. In fact, it is estimated that in Kansas, family physicians have an economic impact of nearly \$880,000 per doctor, per year.

Although this has a significant impact on our region, REAP also recognizes the impact that the Center has for the entire state, with 55 percent of WCGME educated physicians practicing in Kansas. That translates into an estimated \$730 million economic impact to the state.

The local government officials of REAP urge legislators to recognize and acknowledge that this funding would maintain the core activities needed to strengthen and encourage the recruitment, production, and retention of physicians for the state of Kansas.

I respectfully request that the Kansas Legislature support funding for the Wichita Center for Graduate Medical Education to promote continued quality medical care and economic stimulus for the citizens of South Central Kansas, and the State of Kansas.

Thank you again for the opportunity to appear before you today.



February 14, 2008

To: Members of the Senate Ways & Means

Re: Request from WCGME

Dear Chairman Umbarger and Members of the Senate Ways and Means Members:

Thank you for this opportunity to present testimony about WCGME's request on behalf of the Kansas Academy of Family Physicians (KAFP). Our organization has over 1,500 members across the state. The roots of family medicine go back to the historical generalist tradition. The specialty is three dimensional, combining knowledge and skill with a unique process. The patient-physician relationship in the context of the family is central to this process and distinguishes family medicine from other specialties. Family physicians are the only physician specialty whose members are distributed across the state of Kansas in the same manner as the general population. They currently provide by far the majority of primary care to Kansans.

The Kansas Academy of Family Physicians supports the request by WCGME for the funds to support non-reimbursable resident time, additional faculty positions, research infrastructure and to recover GME funding shortfalls. The Wichita campus has traditionally been regarded as being primary care friendly, and indeed is the home of three of the state's four distinguished family medicine residency programs. Kansas needs more family physicians. Support for this request by WCGME will sustain that key issue.

Defining the medical home and moving towards implementing it for Kansas are among the health recommendations of the Kansas Health Policy Authority. The research on the medical home is all based upon a primary care physician- led team to provide the medical home. A recent study shows that if every American had a medical home, health care costs would likely decrease by 5.6 percent, resulting in national savings of \$67 billion dollars per year, with an improvement in the quality of the health care provided. Primary care is essential for the effective and efficient functioning of America's health care delivery system. The value of primary care to reduce overall healthcare spending while improving quality and patient outcomes has been consistently proven. 1-7

Further, the Commonwealth Fund 2006 Health Care Quality Survey ⁸ found that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially.

President Michael L Kennedy MD Kansas City

President-Elect Terry L Mills MD Newton

Vice President Michael L Munger MD Overland Park Jennifer L Brull MD Plainville

Todd A Miller MD Wichita

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Ronald C Brown MD Wichita
Karen E Bruce MD Topeka
Gene Cannata MD Pratt
Deborah Clements MD Kansas Gity

Deborah Clements MD Kansas Ci Christian Cupp MD Scott City Rob Freelove MD Salina Doug Gruenbacher MD Quinter LaDona M Schmidt MD Salina Jon O Sides MD Burlington Gregory T Sweat MD Overland Park

Foundation President Marty Turner MD Rose Hill Resident Representative Jennifer Bacani MD Wichita

Student Representative Ernesto Mendoza Wichita

Executive Director Carolyn N Gaughan CAE

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Graduates of the three Family Medicine residency programs associated with the Wichita campus, Smoky Hill, Via Christi and Wesley, practice high quality, cost effective family medicine in communities throughout the state. Without them many more communities would be critically underserved. Without more of them in the future, we will not be able to effectively provide the medical home that every citizen of the state needs.

The contribution of WCGME graduates to the medical community of the state and to the health of Kansans cannot be measured. Kansas needs WCGME. WCGME needs Kansas.

We earnestly urge you to act favorably upon this request.

n Ganglian

Sincerely,

Carolyn Gaughan, CAE Executive Director

References

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- 2. Shi L, Macinko J, Starfield B, Wulu J, Regan J, Politzer R. The Relationship Between Primary Care, Income Inequality, and Mortality in US States, 1980-1995. *J Am Board Fam Pract*. September 1, 2003 2003;16(5):412-422.
- 3. Shi L, Macinko J, Starfield B, Xu J, Politzer R. Primary care, income inequality, and stroke mortality in the United States: a longitudinal analysis, 1985-1995. *Stroke*. Aug 2003;34(8):1958-1964.
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- **9.** Spann SJ, for the members of Task Force 6 and The Executive Editorial T. Report on Financing the New Model of Family Medicine. *Ann Fam Med.* November 1, 2004 2004;2(suppl_3):S1-21.



623 SW 10th Avenue Topeka KS 66612-1627 785.235.2383 800.332.0156 fax 785.235.5114

www.KMSonline.org

To:

Members of the Legislature

From:

Jerry Slaughter

Executive Director

Date:

February 13, 2008

Subject:

Support for WCGME appropriation request

The Kansas Medical Society would like to take this opportunity to express our strong support for additional state funding for the Wichita Center for Graduate Medical Education (WCGME). WCGME has submitted a funding request that totals \$9.6 million for the coming fiscal year.

As you know, WCGME conducts physician graduate medical education programs (medical residency training programs) in Wichita and Salina. Its record of placing physician graduates in Kansas is exemplary, particularly in the primary care specialties. Over the past five years, for example, nearly two-thirds of its primary care graduates have entered medical practice in the state of Kansas, with many practicing in medically underserved, rural areas.

However, the combination of declining federal financial support and enhanced program accreditation requirements are jeopardizing WCGME's ability to continue to be a major producer of physicians for our state. In order to maintain, and improve upon, its record of success, WCGME needs additional, sustained funding to insure that it continues to meet program accreditation requirements involving research, teaching and administration, as well as adequate funding for resident physician rotations not funded by Medicare.

We recognize that you must make difficult funding decisions with limited state resources. The investment you make in supporting these medical residency training programs will produce well trained physicians for rural and underserved communities all across our state. Assuring an adequate supply of physicians is a very clear, tangible return on that investment. We urge your support of WCGME's request, and thank you for your consideration.

MEDICAL SOCIETY of SEDGWICK COUNTY

1102 S. Hillside • Wichita, Kansas 67211 • Phone (316) 683-7557 • Fax (316) 683-1606 • www.mssconline.org

January 25, 2008

Dear Members of the Kansas Legislature:

The Medical Society of Sedgwick County (MSSC) is a 105-year-old professional organization representing nearly 1,200 physicians who serve the medical needs of individuals from across the state of Kansas. Over the course of the past year, MSSC has sponsored a community-wide effort entitled MERIT (Medical Education Research Improvement Taskforce) designed to understand, support and ultimately expand the community's ability to produce physicians for Kansas. The taskforce is comprised of leaders from the south central Kansas region who represent various organizations and institutions impacted by health care.

Throughout the past year, MERIT has endeavored to gain a clear understanding of the process required to train physicians for the practice of medicine, as well as the costs and institutional supports needed to effectively complete that training. Additionally, we have come to realize the vital impact that our residency training programs have on both the health of our community and the entire state of Kansas.

Unfortunately, we have also discovered the inadequate funding for graduate medical education programs – specifically the Wichita Center for Graduate Medical Education (WCGME). This critical program is in the classic dilemma – shrinking revenues primarily from federal sources and rising program accreditation requirements. The end result is that without significant added funding, the largest producer of physicians for the state of Kansas is at risk, thus placing Kansas communities also at risk.

As a result of this year-long study, the members of MERIT would like to express strong support for the creation of a sustained line-item funding for the Wichita Center for Graduate Medical Education. Additional funding of \$9.6 million for 2008 is needed in order to meet the basic needs of the program. These funds will be used to expand faculty research and teaching time in order to fulfill the accreditation requirements now facing WCGME medical residency programs.

We would like to thank you for your leadership in improving the health and well-being of all Kansans. We hope that you and your committee agree with us in the importance of physician training as an important step to accomplishing those goals.

Sincerely,

Steen Mortensen, M.D.

President

Dennis L. Ross, M.D.

Chair - MERIT

Past President - MSSC

Greeley/Wallace/Hamilton County Family Practice Clinics

321 E Harper <u>Tribune 67879</u> 620-376-4251 104 E 4th
Sharon Springs 67758
785-852-4230

102 East Avenue B <u>Syracuse, KS 67878</u> 620-384-6907

Date: 2/14/2008

Submitted by: Bob Moser, M.D. Address: 321 E Harper

Tribune, Kansas 67879

Submitted to: Members of the Kansas State Legislature,

I am writing this letter to support the request for funding from The Wichita Center for Graduate Medical Education (WCGME). I am asking you to invest in the WCGME program at a level of \$9.6 million in 2008 in training doctors for the good of the citizens of Kansas

I represent part of the successful efforts the Wichita Center for Graduate Medical Education has had in providing physicians for Kansas communities. I attended the University of Kansas School of Medicine and did my residency at the Smoky Hill Family Medicine program, one of the programs WCGME supports in training physicians for Kansas. My wife and I returned to our hometown of Tribune in 1988 to fulfill my Kansas Medical Student Scholarship obligations. I have been in practice here ever since and what was a single provider medical system has grown to a successful multi-county health care system with four family physicians and two mid-level providers. We have a clinic in Sharon Springs that is staffed 5 days a week, a clinic in Tribune where our primary critical access hospital is located and a clinic in Syracuse. The Greeley County Hospital in county owned and in 1992, 24% of its gross revenues came from county tax dollars. With the same numbers of mills that we have had since 1990, last year our county tax dollars represented only 3% of gross revenues as they grew from \$800,000 in 1992 to \$11 million last year.

Two of the four family physicians in our practice graduated from the Smoky Hill residency. Three out of the four family physicians attended the University of Kansas School of Medicine. One of these physicians was part of the first class of students to go to the University of Kansas School of Medicine-Wichita to complete their third and four years of clerkship rotations.

The efforts and programs that WCGME fund have definitely had a significant hand in contributing to our success and without these programs, 70 more counties would be critically underserved. The average age of many of our family physicians is approaching a point where we could see a large number retiring in the next 10 years. The length of time for physicians in the pipeline from college through medical school and residency often takes at least 7 years. If we do not increase the number of students selecting primary care, support the training programs that are producing physicians for Kansas and physicians selecting sites to practice in Kansas, the physician workforce shortage could lead to a serious crisis for Kansans accessing healthcare.

Family medicine's traditions of training in ambulatory and hospital care, caring for adults and children of either sex, and providing maternity and newborn care means that these training programs are often more expensive than others. Unfortunately, even though it has been well shown that family physicians distribute themselves in proportion to the population more than any other type of specialty, training programs are facing funding shortfalls. Most federal funding for physician residency programs comes through Medicare direct and indirect graduate medical education funds. These federal funds have been decreasing and more cuts are expected even with the increased need for more physicians as the baby boomer population continues to age.

Medical education requirements for residents includes scholarly and research activities which causes some funding losses as it takes them out of the revenue production activity of clinical practice. Many of the Wichita residents have required off-site rotations to fulfill their training requirements and the programs are not reimbursed by Medicare for the time residents are off-site, contributing to further financial strains on the program. These programs get students and residents out across our state where they can learn first hand the health care needs of Kansans and how many other successful health care systems are providing that care.

I am currently serving as the Chair for the Kansas Primary Care Collaborative Coordinating Committee that was convened by the University of Kansas School of Medicine to help develop strategies to make sure we have adequate numbers of primary care physicians for Kansas. One of our committee goals is to determine how the physician workforce can be aligned with state and local community needs. Expansion of medical school admissions without consideration of physician distribution will likely perpetuate the concentration of physicians in urban areas and near major medical centers. Policies and programs aimed at selecting students most likely to practice in rural and underserved areas could assist in securing an adequate supply of well-trained primary care physicians. Many of the programs WCGME supports should help address many of the Kansas healthcare workforce needs now and in the future. I urge you to support WCGME's funding request.

Sincerely,

Bob Moser, M.D. Chair, Kansas Primary Care Collaborative Coordinating Committee Greeley County Health Services



1829 College Avenue Manhattan, KS 66502-3381

Jan. 26, 2008

Hon. Members, Kansas State Legislature State Capital Topeka, Kansas

Thank you for the opportunity to offer my written remarks to the issue of the Wichita branch of the University of Kansas School of Medicine and the Wichita Centers for Graduate Medical Education. (WCGHE):

I graduated from the University of Kansas School of Medicine in 1962. I interned at Menorah Medical Center in Kansas City Mo., and then returned to KUMC for four years of General Surgery training, followed by a year as a pediatric surgery resident. I moved to Manhattan in 1968 and joined another Board Certified Surgeon and retired from active patient care in 2000. I am now director of the Manhattan Surgical Hospital. I have had an appointment as a clinical professor at both branches of the Medical School. I have given grand rounds, and for approximately 20 years I was privileged to have Senior Students as Preceptees.

I stayed in Kansas City for my training because I couldn't afford to move my family. Our graduating class was about 96 and at least 10 members of it went to Wichita where St Francis and Wesley were already well known for their post graduate education opportunities.

The opportunity to spend the last two undergraduate clinical years in Wichita had not been enacted by the legislature. In 1982, 1993 and 1997 Surgeons were added to our practice. All were the product of the training program of the now established Wichita Branch of the University of Kansas School of Medicine. They passed their surgical Board Exams on the first try and have become valuable assets to our community, both as highly skilled Surgeons and as good active participating citizens. They certainly are a credit to their training program.

When our son graduated from the Kansas City branch of the Medical School, in1997, he had his plans for surgery training lined up and followed through. He had spent time, while in Pre-med. working as a scrub tech in a local hospital, and in so doing had

developed considerable insight into what he wanted to do. While in medical school he never got to see an appendectomy, a gall bladder operation, a breast biopsy, a hernia repair, a hemorrhoid operation, a heart attack, pulmonary edema, a diabetic coma, etc.! He got to see a lot of neurosurgery, liver, kidney and heart transplants and some exotic diseases, but none of the "bread and butter" diseases. The reasons for this are many and are not the purpose of this letter.

When my daughter, Becky, entered medical school both her brother and I urged her to look to the Wichita Campus for her last two years of undergraduate clinical training. She took our advice and was fortunate enough to be accepted there. I was amazed at the number and variety of cases that she participated in. When it came time to look for residency positions she traveled all over the country and decided that the pediatric program in Wichita was a very highly regarded program. She talked to people in practice who had been through there and she was satisfied that she should continue her post graduate education there. She has been in practice in Manhattan for over a year, associated with five other pediatricians. They serve an area from Lecompton on the east to Salina on the west as well as the area from the Nebraska border to Emporia.

In talking to graduates of both the Medical School and the Graduate School the one weakness of the Wichita program is that they depend way too heavily on their very dedicated, but relatively uncompensated, clinical staff. This is a staff that has the same spirit of mission to provide medical care to not only the surrounding area, but, indeed, to the entire state of Kansas, particularly to the rural areas, a staff that, while dedicated to medical education, is primarily focused on providing patient care, both in the hospital and in their offices. They have also bought into, and have been recognized for, being involved in the non-medical roles of community activity. The net result seems to be that there are not enough hours in the day to organize the very important conferences, the journal clubs, the morbidity/ mortality conferences, infectious disease conferences, etc. that are such a vital part of medical education, (both pre and post graduate), on a regular basis in all departments. Unfortunately, there is little time for these Physicians to do research, or organize meetings on a regular basis.

One of the best investments in medical care and training is the Wichita Branch of the Medical School. To ensure that the facility is able to meet the ever increasing needs of our state I strongly urge you to increase the funding for full time academic faculty in order to meet the accreditation standards for the WCGHE program.

Sincerely

Gene Klingler, MD, Fellow of the American College of Surgeons

fundará

KU. Med 62



Clinical and Health Services Research in Wichita

The KU School of Medicine-Wichita and its affiliated residencies, now Wichita Center for Graduate Medical Education (WCGME), were initially funded by the Kansas State Legislature in the 1970s. At that time, research was not considered essential to the education of good doctors, so research was deliberately not funded. Today, national education leaders believe differently, and residency programs (as well as medical schools) are required to participate in research and/or scholarly activity in order to meet accreditation standards.

Building or developing health-related research in Wichita is important for a number of reasons:

- In order to keep our 14 residency programs in Wichita and Salina accredited, we must strengthen the research productivity of our faculty as well as the involvement of our resident trainees in research and scholarly activity.
- Aside from accreditation requirements, there is much to be gained from research being part of a quality medical education.
- Health care and the resulting health of residents in Wichita, South Central Kansas, and throughout Kansas will improve through quality research and access to groundbreaking treatment options.
- ❖ The recruitment of the best physicians and health professionals to Kansas will be advanced by creating an environment of excellence and scientific inquiry.

The Accreditation Council for Graduate Medical Education (ACGME) is particularly interested in clinical or patient care research, health services research that evaluates the impact and success of health services, and any other research that can improve human health. The ACGME does not require laboratory research. Examples of acceptable research include:

- Using our OB/GYN database of 36,000 patients who delivered their babies at Wesley Hospital since 1997, we can study many conditions and health outcomes to determine predictors of good outcomes.
- We can measure or evaluate various medical practice behaviors, such as providing pre-surgical antibiotics to prevent post-operative infections or using blood thinners to prevent blood clots. We can then develop an education program or computerized standard orders to improve compliance with recommended national standards or care. And finally, we can report an assessment of actual practice behavior to see if our intervention improved the process and/or outcome of medical care.

Office of the Dean 1010 N. Kansas | Wichita, KS 67214-3199 | (316) 293-2600 | Fax (316) 293-2628 | http://wichita.kumc.edu

2-14-08 Attachment 20

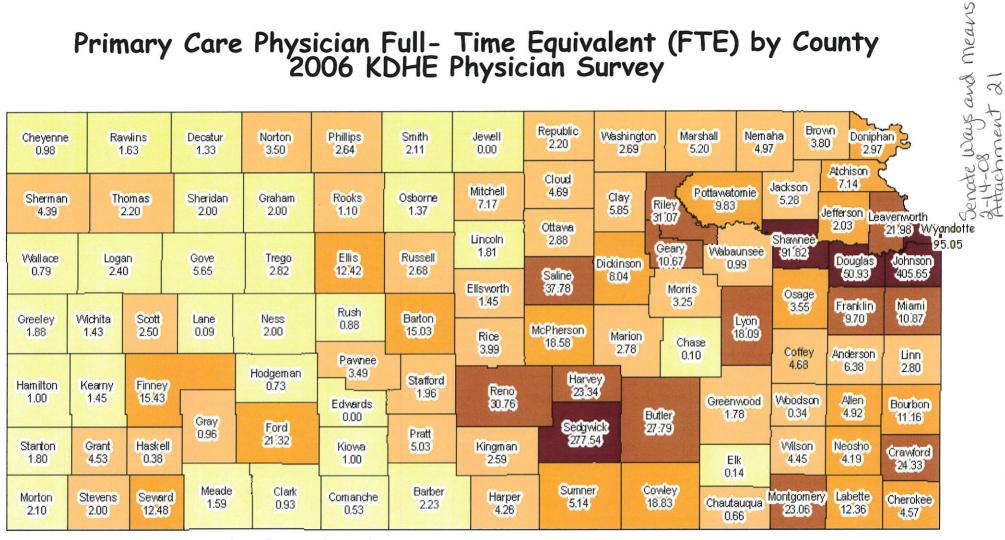
- ❖ At our Clinical Research Institute, we can evaluate the mechanism of drug action or the effectiveness of drugs by performing randomized controlled trials, comparing new drugs to the best older drugs.
- We can study the best approach to critically ill trauma patients in our Level I trauma centers located at both Via Christi Regional Medical Center and Wesley Medical Center.
- ❖ We can study our effectiveness at helping patients modify their behavior, evaluating programs designed to help patients stop smoking, stop drinking alcohol or abusing drugs, change their diet and exercise in order to lose weight and achieve higher levels of fitness.
- We can study clinical approaches and treatments to best care for chronic diseases like diabetes, arthritis, coronary heart disease, heart failure, etc.

Faculty can do these studies and involve residents. As a result, faculty will publish their findings, demonstrating their expertise in research. Residents will get the research experience required by the accrediting agencies. The research can help our local hospitals improve our medical care and health outcomes. The research and scholarly activities will help attract more and better residents to our programs as well as the best doctors to practice in our communities.

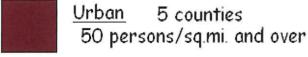
We hope to partner with Wichita State University (WSU) in health care research activities, such as bio-engineering. We now have a national expert at Via Christi and WSU who studies the use of bio-materials (used in the aircraft industry) as materials for human joint replacements.

We do not plan to do laboratory research, and our residency accrediting organization does not require such research. The type of research we will do in Wichita can have immediate impact on citizens of Kansas through improved care and outcomes.

Primary Care Physician Full- Time Equivalent (FTE) by County 2006 KDHE Physician Survey



Population Density Peer Groups



Semi-Urban 12 counties 40.0 149.9 persons / sq. mi.

Densely-Settled Rural 19 counties 20.0-39.9 persons / sq. mi.



Rural 38 counties 6.0 - 19.9 persons / sq. mi.



Frontier 31 counties Fewer than 6.0 persons / sq. mi.

State Average 105 counties 33.4 persons / sq.mi.

y Care Physician FTE Summary by County - 2006

* . . _ .ares for columns H and I are for 1999; Source: Population data are from the US Census Bureau.

A	В	С	D D	E	F	G	Н	da Larg	J	K
County	Total Physician Count (Duplicated)	Primary Care Physician Count (Duplicated)	Primary Care FTE Totals	Percent Primary Care (C/B)	2006 Est. Population	2006 Adjusted Population **	Percent Population <=100% FPL *	Percent Population <=200% FPL	Population To FTE Physician Ratio (G/D)	Population Density Peer Group
ALLEN	15	8	4.92	53%	13,677	13,320	14.9	37.4	2,707	Densely-Settled Rural
ANDERSON	10	. 7	6.38	70%	8,051	7,924	12.8	34.9	1,242	Rural
ATCHISON	43	13	7.14	30%	16,745	15,692	13.3	34.5	2,198	Densely-Settled Rural
BARBER	5	3	2.23	60%	4,974	4,909	10.1	30.7	2,201	Frontier
BARTON	55	20	15.03	36%	27,511	26,739	12.9	36.5	1,779	Densely-Settled Rural
BOURBON	36	15	11.16	42%	14,950	14,626	13.6	34.6	1,311	Densely-Settled Rural
BROWN	19	6	3.8	32%	10,236	10,034	12.9	35.6	2,641	Rural
BUTLER	52	36	27.79	69%	63,147	61,137	7.3	23.2	2,200	Semi-Urban
CHASE	1	1	0.1	100%	3,070	2,957	8.6	33.6	29,570	Frontier
CHAUTAUQUA	. 3	2	0.66	67%	3,953	3,799	12.2	40.3	5,756	Rural
CHEROKEE	13	5	4.57	38%	21,451	21,116	14.3	37.6	4,621	Densely-Settled Rural
CHEYENNE	5	2	0.98	40%	2,911	2,857	9.4	37.1	2,915	Frontier
CLARK	3	3	0.93	100%	2,206	2,160	12.7	34.0	2,323	Frontier
CLAY	13	8	5.85	62%	8,625	8,460	10.2	30.7	1,446	Rural
CLOUD	13	9	4.69	69%	9,594	8,932	10.8	32.7	1,904	Rural
COFFEY	15	7	4.68	47%	8,701	8,531	6.6	27.9	1,823	Rural
COMANCHE	2	2	0.53	100%	1,884	1,814	10.2	34.7	3,423	Frontier
COWLEY	37	23	18.83	62%	34,931	33,123	12.9	33.6	1,759	Densely-Settled Rural
CRAWFORD	77	35	24.33	45%	38,059	36,245	16.0	38.1	1,490	Semi-Urban
DECATUR	12	3	1.33	25%	3,120	2,999	11.6	38.6	2,255	Frontier
DICKINSON	20	10	8.04	50%	19,322	18,984	7.5	28.3	2,361	Densely-Settled Rural
DONIPHAN	4	4	2.97	100%	7,865	7,474	11.9	35.8	2,516	Densely-Settled Rural
DOUGLAS	152	76	50.93	50%	112,123	103,409	15.9	32.0	2,030	Urban
EDWARDS	3	0	0.0	0%	3,138	3,077	10.4	36.3	2,000	Frontier
ELK	3	2	0.14	67%	3,077	2,991	13.8	39.3	21,364	Frontier
ELLIS	76	21	12.42	28%	26,926	25,667	12.9	31.8	2,067	Densely-Settled Rural
ELLSWORTH	6	4	1.45	67%	6,332	5,506	7.2	24.3	3,797	Rural
FINNEY	51	19	15.43	37%	39,097	38,525	14.2	39.9	2,497	Densely-Settled Rural
FORD	59	27	21.32	46%	33,783	33,001	12.4	37.4	1,548	Densely-Settled Rural
FRANKLIN	38	11	9.7	29%	26,513	25,921	7.7	26.7	2,672	Semi-Urban
GEARY	40	12	10.67	30%	24,174	23,563	12.1	40.2	2,208	Semi-Urban
GOVE	7	7	5.65	100%	2,721	2,668	10.3	33.3	472	Frontier
GRAHAM	3	3	2	100%	2,677	2,608	11.5	36.8	1,304	Frontier
GRANT	12	5	4.53	42%	7,552	7,481	10.1	32.8	1,651	Rural
GRAY	1	1	0.96	100%	5,852	5,711	9.1	30.1	5,949	Rural
GREELEY	4	3	1.88	75%	1,331	1,304	11.6	35.1	694	Frontier
GREENWOOD	7	2	1.78	29%	7,067	6,876	12.5	35.9	3,863	Rural
HAMILTON	2	1	1.70	50%	2,594	2,551	15.7	39.9	2,551	Frontier
HARPER	8	6	4.26	75%	5,952	5,784	11.6	34.4	1,358	Rural
HARVEY	69	30	23.34	43%	33,643	32,203	6.4	24.1	1,380	Semi-Urban
HASKELL	2	1	0.38	50%	4,171	4,136	11.6	37.5	10,884	Rural
HODGEMAN	1	1	0.73	100%	2,071	2,036	11.5	30.8	2,789	Frontier
		9		82%	13,500					
JACKSON JEFFERSON	11	1	5.28 2.03	17%	18,848	13,269 18,589	8.8 6.7	26.3 21.9	2,513 9,157	Rural Densely-Settled Rural
					3,324		5101 Day 101 -0		9,157	
JEWELL	1 504	0	0.0	0%	516,731	3,279	11.7	37.3	1 202	Frontier
JOHNSON	1,584	668	405.65	42%		511,753	3.4	10.8	1,262	Urban
KEARNY	4	4	1.45	100%	4,469	4,424	11.7	35.9	3,051	Frontier
KINGMAN	8	3	2.59	38%	7,975	7,777	10.6	28.7	3,003	Rural
KIOWA	1	11	1	100%	2,969	2,861	10.8	33.6	2,861	Frontier
LABETTE	50	15	12.36	30%	22,203	21,346	12.7	36.2	1,727	Densely-Settled Rural
LANE	2	1	0.09	50%	1,797	1,774	8.2	31.1	19,711	Frontier
LEAVENWORTH	134	38	21.98	28%	73,628	66,993	6.7	19.8	3,048	Semi-Urban
LINCOLN	2	2	1.81	100%	3,396	3,320	9.7	36.4	1,834	Frontier

^{*} Year 1999 --- Source: U.S. Census Bureau

^{**} Subject to the effects of rounding

<u>P</u>′ ry Care Physician FTE Summary by County - 2006

* ...gures for columns H and I are for 1999; Source: Population data are from the US Census Bureau.

A	В	С	THE DOMESTIC	E	F.	G	Н	1	J –	K
County	Total Physician Count (Duplicated)	Primary Care Physician Count (Duplicated)	Primary Care FTE Totals	Percent Primary Care (C/B)	2006 Est. Population	2006 Adjusted Population **	Percent Population <=100% FPL *	Percent Population <=200% FPL *	Population To FTE Physician Ratio (G/D)	Population Density Peer Group
LINN	5	5	2.8	100%	9,962	9,831	11.0	30.7	3,511	Rural
LOGAN	6	4	2.4	67%	2,675	2,618	7.3	35.4	1,091	Frontier
LYON	57	22	18.09	39%	35,369	33,756	14.5	37.2	1,866	Semi-Urban
MARION	11	4	2.78	36%	12,760	11,995	9.2	32.9	4,315	Rural
MARSHALL	. 29	9	5.2	31%	10,349	10,105	6.7	22.7	1,943	Rural
MCPHERSON	40	25	18.58	63%	29,380	27,743	8.3	32.0	1,493	Densely-Settled Rural
MEADE	4	1	1.59	25%	4,561	4,447	9.3	34.5	2,797	Frontier
MIAMI	50	14	10.87	28%	30,900	30,154	5.5	18.7	2,774	Semi-Urban .
MITCHELL	13	10	7.17	77%	6,299	5,954	9.5	27.8	830	Rural
MONTGOMERY	62	26	23.06	42%	34,692	33,792	12.6	35.2	1,465	Semi-Urban
MORRIS	7	5	3.25	71%	6,046	5,971	9.0	33.9	1,837	Rural
MORTON	11	4	2.1	36%	3,138	3,081	10.5	30.2	1,467	Frontier
NEMAHA	16	8	4.97	50%	10,374	9,876	9.1	32.2	1,987	Rural
NEOSHO	21	8	4.19	38%	16,298	15,820	13.0	38.1	3,776	Densely-Settled Rural
NESS	2	2	2	100%	2,946	2,867	8.7	31.0	1,434	Frontier
NORTON	10	4	3.5	40%	5,584	4,794	10.5	36.2	1,370	Rural
OSAGE	5	4	3.55	80%	16,958	16,725	8.4	26.8	4,711	Densely-Settled Rural
OSBORNE	6	2	1.37	33%	3,978	3,859	10.4	37.3	2,817	Frontier
OTTAWA	4	3	2.88	75%	6,168	5,977	8.6	25.3	2,075	Rural
PAWNEE		7	3.49	54%	6,515	5,611	11.8	31.6	1,608	Rural
	13	4	2.64	40%	5,444	5,301	10.0	30.6	2,008	Rural
PHILLIPS	10		9.83	58%	19,220	18,938	9.8	28.3	1,927	Densely-Settled Rural
POTTAWATOMIE	24	14 7	5.03	58%	9,436	9,111	9.4	30.1	1,811	Rural
PRATT	12		1.63	44%	2,643	2,587	12.5	34.1	1,587	Frontier
RAWLINS	9	4			63,706		10.9	31.3	1,965	Semi-Urban
RENO	104	45	30.76	43%	5,033	60,453	9.1	34.9	2,224	Rural
REPUBLIC	7	3	2.2	43%	10,295	4,893		32.8	2,360	Rural
RICE	6	5	3.99	83%	62,527	9,416	10.7	40.2	7 H 10 C 10	Semi-Urban
RILEY	97	42	31.07	43%	2000 000 000 000	53,213	20.6		1,713	Rural
ROOKS	2	2	1.1	100%	5,290	5,093	9.8 9.7	34.9	4,630	Frontier
RUSH	3	2	0.88	67%	3,317	3,229		35.7	3,669	Rural
RUSSELL	7	6	2.68	86%	6,740	6,531	12.0	36.2	2,437	
SALINE	117	53	37.78	45%	54,170	52,727	8.8	27.3	1,396	Semi-Urban
SCOTT	5	3	2.5	60%	4,643	4,557	5.1	28.4	1,823	Rural
SEDGWICK	923	448	277.54	49%	470,895	464,617	9.5	25.8	1,674	Urban
SEWARD	39	17	12.48 .	44%	23,404	22,990	16.9	42.1	1,842	Densely-Settled Rural
SHAWNEE	419	172	91.82	41%	172,693	167,797	9.6	25.6	1,827	Urban
SHERIDAN	2	2	2	100%	2,600	2,556	15.7	37.1	1,278	Frontier
SHERMAN	28	7	4.39	25%	5,981	5,847	12.9	35.8	1,332	Rural
SMITH	12	4	2.11	33%	4,024	3,915	10.7	36.6	1,855	Frontier
STAFFORD	3	2	1.96	67%	4,435	4,356	11.8	36.4	2,222	Rural
STANTON	2	2	1.8	100%	2,232	2,177	14.9	33.5	1,209	Frontier
STEVENS	6	2	2	33%	5,287	5,227	10.3	31.8	2,614	Rural
SUMNER	22	7	5.14	32%	24,441	24,033	9.5	28.5	4,676	Densely-Settled Rural
THOMAS	24	3	2.2	13%	7,468	7,187	9.7	27.1	3,267	Rural
TREGO	3	3	2.82	100%	2,993	2,884	12.3	30.8	1,023	Frontier
WABAUNSEE	2	2	0.99	100%	6,895	6,783	7.3	23.5	6,852	Rural
WALLACE	4	3	0.79	75%	1,557	1,532	16.1	36.2	1,939	Frontier
WASHINGTON	6	6	2.69	100%	5,944	5,740	10.1	35.5	2,134	Rural
WICHITA	3	2	1.43	67%	2,288	2,263	14.8	40.3	1,583	Frontier
WILSON	13	6	4.45	46%	9,889	9,651	11.3	41.1	2,169	Rural
WOODSON	1	1	0.34	100%	3,507	3,393	13.2	39.4	9,979	Rural
WYANDOTTE	587	181	95.05	31%	155,509	153,917	16.5	38.2	1,619	Urban
STATEWIDE	5,676	2,423	1,547.68	43%	2,764,075	2,682,125	10.9	32.8	1,733	STATEWIDE

^{*} Year 1999 — Source: U.S. Census Bureau ** Subject to the effects of rounding

Statewide Data on Kansas Nursing Home Revenues and Expenses

rptEconImpact_All

The following information comes from the required full year Medicaid cost reports covering the State fiscal year 2008 (July 1, 2006 through June 30, 2007) using CY2006 costs.

Total Number of Facilities reporting-only those that have filed full year costs for CY 2006:

336

Occupancy Data

Total Medicaid Days:

3,905,799

Total Medicare Days:

568,616

Total Private Pay Days:

2,572,829

Total Resident Days:

7,047,244

Avg. Occupancy Data:

84.51%

Avg. Medicaid Utilization:

55.48%

Economic Expenditures - Allowable Expenditures

Total Direct Health Care Costs:

\$456,772,009

Total Indirect Health Care Costs:

\$244,877,454

Total Operating Costs:

\$176,366,142

Total Ownership Costs:

\$64,087,332

Total Liability Insurance:

\$12,205,889

_ 1 20200 2

...,200,000

Total Other Insurance:

\$5,165,991

Criminal Background Checks: Total Utilities:

354,770

Total Property Tax:

\$27,142,047 \$4,281,074

Employee Salaries and Number Employed

Total Number of Employees:

28,305

Direct Care Employees (2):

16,640

Indirect Care Employees (1):

11,665

Total Salaries Paid:

\$628,653,665

Direct Care Salaries:

\$413,497,381

Indirect Care Salaries:

\$215,156,284

Wednesday, January 30, 2008

Kansas Health Care Association Economic Impact Statements

Page 1 of 1

^{1 -} Indirect Care includes: Dietary, Laundry, Housekeeping, Medical Records, OT, PT, ST, Recreation Therapy, Respiratory Therapy, Resident Activity, Social Work, Other Health Care, Psych Therapy, Administrator, Co-Admin, Other Admin, Plant Operating.

^{2 -} Direct Care includes: LMHT, LPN, Med Aide, Nurse Aide, RN, Restorative Aid

Data on Kansas Nursing Home Revenues and Expenses

The following information comes from the Medicaid cost reports covering the State Fiscal Year 2008 (July 1, 2006 through June 30, 2007) using CY2006 costs.

Provider Number:

Facility Name:

Economic Impact

Medicaid profit/ shortfall:

(\$52,907,781)

Total net return provider enhancement (1):

\$32,565,645

1 - No Waiver Provider enhancement model.

Senator	District	Number of Homes	Medicaid Profit/Shortfall	Total Net Return Provider Enhancement		
S. Morris	39	0	(#2 F96 FFF)	¢574.040		
	18	9 7	(\$2,586,555) (\$735,605)	\$571,049 \$699,857		
L. Kelly V. Schmidt	20	7	(\$735,695)			
	33	16	(\$4,055,181)	\$2,005,129 \$1,130,478		
R. Teichman D. Umbarger	14	15	(\$1,729,902) (\$1,160,371)	\$1,130,478 \$1,479,657		
M Taddiken	21	22	(\$1,807,815)	\$1,002,423		
C Steineger	6	3	(\$28,077)	\$598,373		
J Schodorf	25	6	(\$395,546)	\$834,161		
D Betts	29	2	(\$366,265)	\$453,855		
G Goodwin	32	12	(\$807,595)	\$859,630		
J Emler	35	18	(\$2,106,954)	\$1,100,457		
C McGinn	31	8	(\$1,841,208)	\$825,101		
D Wysong	7	1	(\$605,582)	\$266,072		
Total		126	(\$18,226,746)	\$11,826,242		
Medicaid Pro	∣ fit/ Shortfall	lis the gap between th	e cost of care for the Medicai	d client and what the state reimburses for Medi	caid.	
Based on CY	2006 CRD	L from KDOA.				



February 14, 2008

600 Foxgate Road Louisville, KY 40223 Tel: (502) 245-8895 Fax: (502) 245-9425

My name is Joseph Lubarsky. I am president of Eljay, LLC, a company that provides consulting services on Medicaid payment system design and funding for nursing facilities. I have been involved in the design and implementation of provider assessment programs in 14 of the 16 states that have implemented these assessments in the last four years. This includes all 12 states that utilized waivers to exclude providers from the assessment or charges them varying assessment rates. I also author an annual study on the shortfall in Medicaid funding in nursing homes which identifies the difference by state, on average, between Medicaid reimbursement per day and providers' per diem costs.

Today, 32 states plus the District of Columbia have implemented provider assessments in nursing homes to enhance federal funding for Medicaid-covered services. These states generate federal funding of approximately \$4.0 billion dollars annually from this process. In addition, another \$350 million is generated annually from assessments that are used by states for other purposes, such as balancing budget deficits.

As stated previously, 16 of these states implemented provider assessments in the last four years. Two have since repealed their assessment. In those two cases, over 70% and 50% of the assessments in New Mexico and Washington respectively were used, not to enhance nursing home rates, but instead to subsidize budget shortfalls. When the economy improved in 2005-2006, the tax revenues were no longer needed and the assessment repealed

The remaining 14 states draw down annual federal matching funds of approximately \$1.5 billion from this process. Twelve of these programs involve waivers that exclude certain providers from the assessment, assess lower rates for others, or provide for a combination of both. These waivers allow states to exclude many of the providers with low Medicaid volume from the assessment. Providers with low Medicaid volume typically do not benefit from the assessment in that the assessment will often exceed their rate enhancement.

The assessment bills proposed in Kansas in previous years included waivers to exclude classes of providers that generally were low volume Medicaid providers. Those bills were not supported by the Kansas Association of Homes and Services for the Aging even though almost all of their members would have received rate enhancements greater than their total assessment.

Under this Bill, the assessment would be uniformly imposed on all providers, thereby requiring no formal review or approval process with CMS. Even without a waiver, only 10% of providers receive less in rate increases than their total assessment cost. The other 90% have enough Medicaid residents in their facility that the rate enhancement for these residents is greater than, and typically far exceeds, the total assessment cost. With few exceptions, those that lose are strictly those that choose not to accept Medicaid residents or do so only after the private pay resident has exhausted their resources.

For the first time, the Bill details how the funds would be spent. The funds would be for used for purposes that very likely would not be funded through your normal rate setting appropriation, but would most benefit those providers who are caring for higher volumes of Medicaid patients by:

- 1. Reimbursing their cost increases in direct care on a more timely basis, rather than having to wait three years for rebasing;
- 2. Providing greater funding for cognitively impaired and dementia patients;
- 3. Incentivizing providers to better manage their costs in administration and in areas not directly impacting patient care; and
- 4. Providing more funds to allow higher volume Medicaid facilities to renovate and modernize their facilities.

Candidly, there are two primary concerns raised relative to development of a provider tax program:

- A concern that the state will not use the funds as intended and will instead use
 them to either balance their budget or to fund other programs. This is what
 happened in New Mexico and Washington, and why providers were supportive of
 the assessment repeal. This risk can be mitigated through statutory language
 specifying how the assessment funds are to be used; and
- 2. The supposition that facilities will raise the rates to the private pay patients to subsidize the cost of the assessment. In other states, where a high majority of the assessment dollars have been used for rate increases, to my knowledge, there has been no widespread complaints from families of private pay residents that rates were increased as a result of the provider assessment. This is the result of Medicaid rate increases far exceeding the total assessment increase, thereby mitigating the need to assess private pay residents. The only isolated incidents have come from families of residents in facilities with little or no Medicaid census that were not waived from the assessment. In these circumstances, the facilities made a business decision to charge their residents.

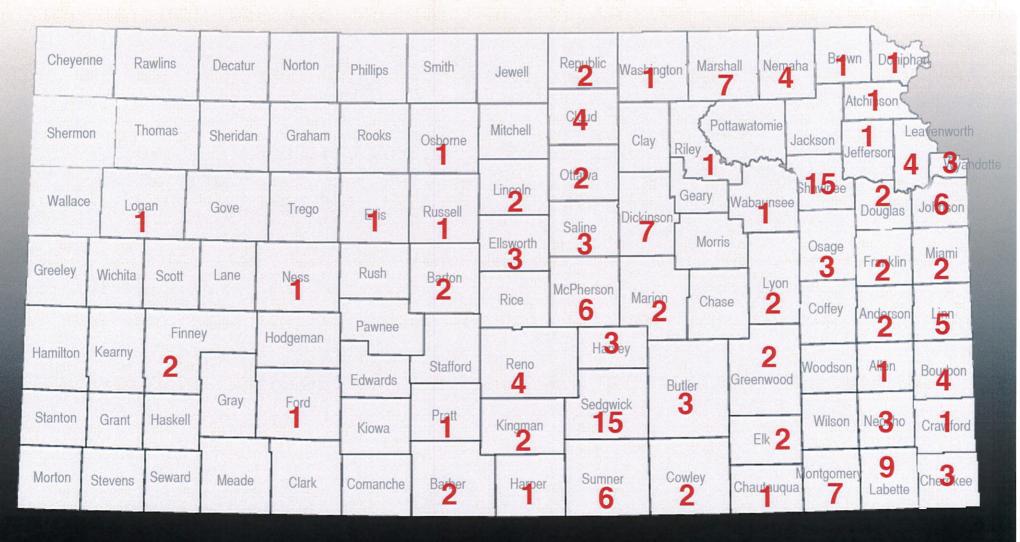
Another issue raised specific to Kansas is the requirement that Medicaid rates cannot exceed private pay rates, which might force providers to increase their private pay rates. There is no federal rule that requires Medicaid rates be less than private pay rates. Therefore the rule could be repealed. As an alternative, as they did in Arkansas which had a similar provision, the limitation compares the Medicaid rate to the average rate paid from a combination of both government payer sources, Medicare and Medicaid.

In closing, based upon reviewing both the legislation and the provider assessment and rate enhancement models prepared to date, I see little downside and tremendous upside to this legislation as drafted:

- 1. It generates \$80 million in total funds; \$47 million of which are federal dollars;
- 2. 20% of these funds are earmarked for the state for adult care programs;
- 3. Higher volume Medicaid providers will have significantly more resources than they would normally receive through the budgetary appropriations process for more timely payment of cost increases in direct care; for better managing costs in areas not directly impacting patient care; for caring for residents with more severe cognitive impairments; and for improving and modernizing their physical plants;
- 4. The assessment burden will not fall on private pay residents in 90% or more of the facilities because these facilities receive rate enhancements greater than, and in most cases, far exceeding their total assessment cost; and
- 5. There is no intent on the part of the federal government to repeal or modify provider assessments, and in fact, federal law locks in the current regulations regarding provider assessments until at least 2011.

Based upon my extensive experience and expertise in this area, the state has no risk; the only risk falls upon the providers in that the statutory language and assessment sharing arrangement could be modified in future legislative sessions. It is a risk that Medicaid providers in other states have been willing to take to improve the adequacy of Medicaid payment and provide resources to improve quality of care and the resident's physical environment that are simply not attainable in the normal state budgetary process.

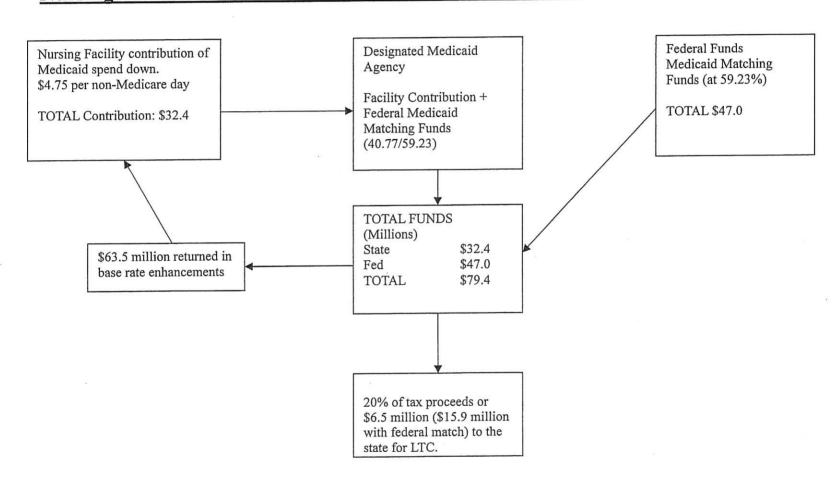
Nursing Home & Assisted Living Facility Closings by County (1997 - 2007)



Quality Assurance Assessment

Nursing Facilities The State

Federal



SENATE BILL 585

- This is not a "tax" on private pay residents of nursing facilities. The Quality Assurance Fee is paid by providers in order to allow the state of Kansas to have more federal dollars returned to Kansas to help care for frail and elderly citizens.
- The vast majority of private pay residents (over 80%) live in facilities that will receive a net benefit from the Quality Assurance Fee as proposed in SB 585. This will relieve the need to fund the gap in Medicaid funding by increasing private pay rates.
- SB 585 proposes a time-tested method where Kansas Medicaid utilizes dollars from the fee paid by providers to spend as Medicaid certified expenditures qualifying for additional federal matching dollars. This process has been utilized by states since 1992 and is currently used by 32 states and the District of Columbia.
- This is not a new concept for Kansas: In 2004 the Kansas Legislature passed House Substitute for Senate Bill 12, establishing a provider assessment for hospitals. SB 585 proposes to do the same thing for nursing facilities.
- SB 585 returns 80% of the revenue it generates to providers in order to enhance quality care for the frail and elderly and 20% of the revenue is retained by the state. Recently two states eliminated similar fees because little or none of the revenue generated from the fee was being returned to providers and left them with significant losses. SB 585 safeguards this from happening in Kansas.
- SB 585 benefits Medicaid residents by:
 - Enhancing rates paid for care that reduces the current gap between rates and cost of care;
 - o Providing resources and incentives for providers to improve their physical plant creating a more homelike environment;
 - Making available additional funding for direct care support such as caregiver/staff retention and less turnover.
- SB 585 benefits Private Pay residents by:
 - Reducing the strain on private pay rates that currently help fund the Medicaid shortfall;
 - o Lessening pressure on providers to increase private pay rates;
 - o Improving facilities to create a more home-like environment.
- SB 585 benefits Providers/Care Givers by:
 - Making available additional funding for direct care support to increase wages and retain employees;
 - o Attracting new employees with higher wages; and
 - o Providing incentives to address capitol improvements to facilities.
- SB 585 benefits the State of Kansas by:
 - Gaining funds outside the state budget to enhance LTC provider rates and help Kansas Medicaid pay for services;
 - Retaining 20% of the new revenue from the fee, which is eligible to be spent on other Medicaid services:
 - o Creating additional tax revenue when providers spend funds from enhanced rates.



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Testimony
Senate Ways and Means
Jim Klausman, Midwest Health Management
Kansas Health Care Association
February 14, 2008

Chairman Umbarger and Members of the Committee:

My name is Jim Klausman and I am the Chairman of the Board at KHCA as well as CEO of Midwest Health Management. The Kansas Health Care Association appreciates the opportunity to comment in support of SB 585. The Kansas Health Care Association (KHCA) believes that by partnering with the state Medicaid agency we can bring in additional Federal dollars to Kansas to help homes that are struggling to stay in business.

At Midwest Health Management, I am proud to say we employ 1200 dedicated employees in 26 homes across the state of Kansas. The total number of residents in our skilled nursing facilities is over 600 residents.

Medicaid does not cover the entire cost for providers to care for their residents. Currently, our businesses lose an average of \$13.55 per patient day. In order to deliver quality of care, nursing home providers have had to implement cost-saving measures, operate with reduced margins and also pass on some of these costs to the private pay residents. Kansas nursing homes need sustainable and consistent funding to assure quality of care for Kansas' most vulnerable citizens. It is time for the federal government to be a partner with the state to relieve some of the burden.

This quality assessment is a way to access federal dollars that Kansas would not otherwise receive. Often nursing homes are the largest employer in a community. Our businesses become vital to the future of our towns and neighborhoods. So the federal dollars coming back to Kansas also would be putting federal dollars into local communities. The economic impact would have a ripple effect throughout Kansas communities.

This is not a "tax" on private pay residents of nursing facilities. The Quality Assurance Fee is paid by providers in order to allow the state of Kansas to have more federal dollars returned to Kansas to help care for frail and elderly citizens. The vast majority of private pay residents (over 80%) live in facilities that will receive a net benefit from the Quality Assurance Fee as proposed in SB 585. This will relieve the need to fund the gap in Medicaid funding by increasing private pay rates.

I understand this is a complex process which requires a great deal of trust between nursing facilities and the state who will be handling the funds, but I am willing to suggest that this would be a workable partnership like the one that currently exists with the Kansas hospitals.

We ask this committee for your support of senate bill 585.



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kcal ahca

Testimony
Senate Ways and Means
Steve Hatlestad, Americare
Kansas Health Care Association
February 14, 2008

Chairman Umbarger and Members of the Committee:

My name is Steve Hatlestad and I am a Regional Vice President with Americare Systems, Inc. I support SB 585 for the following reasons:

- SB 585 proposes a time-tested method where Kansas Medicaid utilizes dollars from the fee
 paid by providers to spend as Medicaid certified expenditures qualifying for
 additional federal matching dollars. This process has been utilized by states since 1992
 and is currently used by 32 states and the District of Columbia.
- This is not a new concept for Kansas: In 2004 the Kansas 1egislature passed House Substitute for Senate Bill 12, establishing a provider assessment for hospitals. SB 585 proposes to do the same thing for nursing facilities.
- SB 585 returns 80% of the revenue it generates to providers in order to enhance quality care for the frail and elderly and 20% of the revenue is retained by the state.
- This is not a "tax" on private pay residents of nursing facilities. The Quality Assurance Fee is paid by providers in order to allow the state of Kansas to have more federal dollars returned to Kansas to help care for frail and elderly citizens.
- The vast majority of private pay residents (over 80%) live in facilities that will receive a net benefit from the Quality Assurance Fee as proposed in SB 585. This will relieve the need to fund the gap in Medicaid funding by increasing private pay rates.
- Recently two states eliminated similar fees because little or none of the revenue generated from the fee was being returned to providers and left them with significant losses. SB 585 safeguards this from happening in Kansas.

We ask this committee for your support of senate bill 585.



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Testimony
Senate Ways and Means
Jeff Moszeter, Eventide Convalescent Center
Kansas Health Care Association
February 14, 2008

Chairman Umbarger and Members of the Committee:

My name is Jeff Moszeter and I am the Administrator at Eventide Convalescent Center in Topeka. I support SB 585 for the following reasons:

- SB 585 benefits Medicaid residents by:
 - 1. Enhancing rates paid for care that reduces the current gap between rates and cost of care;
 - 2. Providing resources and incentives for providers to improve their physical plant creating a more homelike environment;
 - 3. Making available additional funding for direct care support such as caregiver staff retention and less turnover.
- SB 585 benefits Private Pay residents by:
 - 1. Reducing the strain on private pay rates that currently help fund the Medicaid shortfall;
 - 2. Improving facilities to create a more home-like environment.
- SB 585 benefits Providers / Care Givers by:
 - 1. Making available additional funding for direct care support to increase wages and retain employees;
 - 2. Attracting new employees with higher wages; and
 - 3. Providing incentives to address capitol improvements to facilities.
- SB 585 benefits the State of Kansas by:
 - 1. Gaining funds outside the state budget to enhance LTC provider rates and help Kansas Medicaid pay for services.

We ask this committee for your support of Senate Bill 585.



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Testimony Presented to the Senate Ways and Means Committee
Requesting Consideration of Amendments to SB 585
By
Mike Oxford, Executive Director
February 14, 2008

Dear Senator Umbarger and Committee Members,

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The Topeka Independent Living Resource Center (TILRC) is a civil and human rights organization. Our mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. TILRC has been providing cross-age, cross-disability advocacy and services for over 25 years to people across the state of Kansas. Our agency has been particularly interested in and committed to assuring that people who require long term care services have access to information, services and supports that offer choices; choices that promote freedom, independent lifestyles and dignity, including the dignity of risk.

We believe that over the years the State of Kansas has increasingly come to support these interests, as well, as evidenced by increasing the number of home and community program options and by increasing the funding for these programs. At the same time, there has been a significant struggle to continue to find the budgetary resources necessary to fund both the facilities and the home and community alternatives to facility-based long term care services.

SB 585 proposes a method for increasing revenue dedicated to long term care services that would be new to Kansas. This funding mechanism is based on the nursing facility census and has been used by many states over the years to increase funding for the nursing facility industry. Some of the states that have utilized this method have also been very creative in demonstrating leadership in the development and delivery of home and community services and supports. This method not only raises the targeted revenue, but by having and using this kind of direct revenue, these states have also been able to avoid additional costs to the general revenue and have been able to use this "cost savings" to further fund creative home and community service options. Other states have raised billions of dollars through a similar fee. In tight budget times, shouldn't we be looking for ways, especially tried and tested ways, to raise revenue for the growing demand for long term care services?

The need for assuring the availability and quality of long term services and supports exists in all settings. SB 585 offers a resource for skilled nursing facilities to promote quality assurance activities and offers resources up to 20% of the amounts collected from their proposed fee for adult care. We would like to offer the attached amendment to SB 585.

Advocacy and services provided by and for people with disabilities.

SB 585, Page 2 February 14, 2008

In our proposed amendment, we suggest clarifying the commitment of resources by removing the ambiguous term "adult care" on page 3 of the bill and replacing it with a specific reference to "home and community based long term services and supports for individuals who otherwise qualify for nursing facility level of care." We believe that the resources derived from a quality assurance fee based on facility census counts should be committed to an institutional equivalent, such as home and community based services where recipients must meet an analogous level of care to qualify.

We think our amendment underscores the state's commitment to assuring that people have choices in long term care services. Our amendment is part of a long tradition in our state of supporting independence and dignity of long term care service recipients. Finally, we hope that our amendment is part, along with the MFP grant project, of a new beginning addressing the potential of nursing facilities working together with home and community agencies to create the seamless, quality long term service and support system that out state's consumers deserve.

We have communicated with representatives from KHCA, who support our amendatory language change.

Session of 2008

SENATE BILL No. 585

By Committee on Ways and Means

2-8

9 AN ACT concerning adult care homes; providing for assessments on cer-10 tain nursing facilities; prescribing powers, duties and functions for the secretary of aging; creating the quality assurance assessment fund; pro-11 viding for implementation and administration. 12 14 Be it enacted by the Legislature of the State of Kansas: 15

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Section 1. As used in sections 1 through 6, and amendments thereto, unless the context requires otherwise:

(a) Words and phrases have the meanings respectively ascribed thereto by K.S.A. 39-923 and amendments thereto.

"Skilled nursing care facility" means a licensed nursing facility providing skilled nursing care.

(c) "Exempt facility" means a skilled nursing care facility from a nonwaivered program. Exempt facility shall include the Kansas soldiers' home and the Kansas veterans' home.

(d) "Patient day" means a calendar day of care provided to a skilled nursing care facility resident, which includes the day of admission and excludes the day of discharge, except that when admission and discharge occur on the same day, one day of care shall be deemed to exist.

(e) "Non-medicare part A day" means those patient days not funded by the medicare program or by a medicare advantage or special needs

Sec. 2. (a) Except as otherwise provided in this section and in section 6, and amendments thereto, there is hereby imposed and the secretary of aging shall assess a monthly assessment, hereinafter called a quality assurance fee, on each skilled nursing care facility imposed at a rate of \$4.75 per non-medicare part A patient day to finance initiatives designed to maintain or improve the quantity and quality of care in skilled nursing care facilities in Kansas.

(b) Each skilled nursing care facility that is an exempt facility is exempt from all quality assurance fees imposed pursuant to this section.

(c) The secretary of aging shall calculate the monthly amount of the quality assurance fee owed by each skilled nursing care facility by multiplying the total number of days of care provided to non-medicare residents by the skilled nursing care facility for such month, as provided to 9.1

the secretary of aging pursuant to section 3, and amendments thereto, by the applicable assessment rate for the twelve-month period in which such month occurs.

(d) The amount assessed pursuant to this section is due and payable 30 days after the end of the month for which it has been assessed. The secretary of aging is authorized to establish delayed payment schedules for skilled nursing care facilities that are unable to make assessment payments when due and payable under this section due to financial difficulties, as determined by the secretary of aging.

(e) The payment of the quality assurance fee to the secretary of aging pursuant to sections 1 through 6, and amendments thereto, is an allowable cost for medicaid reimbursement purposes. A rate adjustment pursuant to subsection (e)(2) of section 4, and amendments thereto, shall be made, effective on the date of imposition of the assessment, to reimburse the portion of this cost imposed on medicaid days.

Sec. 3. (a) Each skilled nursing care facility shall file a report with the department on aging each month that sets forth the total number of days of care such skilled nursing care facility provided to non-medicare residents during the preceding month.

(b) Each skilled nursing care facility shall prepare and submit to the secretary of aging any additional information required and requested by the secretary of aging to implement or administer the provisions of sections 1 through 6, and amendments thereto.

Sec. 4. (a) There is hereby created in the state treasury the quality assurance fund, which shall be administered by the secretary of aging. All moneys received for the assessments imposed pursuant to section 2, and amendments thereto, including any penalty assessments imposed thereon pursuant to section 5, and amendments thereto, shall be remitted to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the quality assurance fund. All expenditures from the quality assurance fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of aging or the secretary's designee.

(b) All moneys in the quality assurance fund shall be used to finance initiatives to maintain or improve the quantity and quality of skilled nursing care in skilled nursing care facilities in Kansas. No moneys credited to the quality assurance fund shall be transferred to or otherwise revert to the state general fund at any time.

(c) Any moneys received by the state of Kansas from the federal government as a result of federal financial participation in the state medicaid program that are derived from the quality assurance fee shall be used to

home and community based long term services and supports for individuals who otherwise qualify for nursing facility level of care.

SB 585

9.7

finance actions to maintain or increase healthcare in skilled nursing care facilities.

- (d) An amount equal to not more than 20% of the aggregate quality assurance fee imposed pursuant to section 2, and amendments thereto, including any penalty assessments imposed thereon pursuant to section 5, and amendments thereto, plus the corresponding amount of federal matching moneys shall be used for adult care.
- (e) (1) The remaining amount in the quality assurance fund which shall not be less than 80% of the aggregate quality assurance fee imposed pursuant to section 2, and amendments thereto, including any penalty assessments imposed thereon pursuant to section 5, and amendments thereto, plus the corresponding amount of federal matching moneys shall be used only for:
- (A) Enhancements to the property component of the medicaid rate through implementation of a fair rental value payment system;
- (B) rate enhancements for cognitively impaired residents using the cognitive performance scale;
 - (C) rate enhancements for cost containment;
 - (D) removal of the 85% occupancy penalty;
- (E) an additional inflationary allowance in addition to the current nursing home market basket inflationary adjustment in the direct health care cost center; and
 - (F) a pass-through for the Medicaid portion of property taxes.
- (2) The remaining amount shall not be used directly or indirectly to replace existing state expenditures for payments to skilled nursing care facilities for providing services pursuant to the state medicaid program. Of the amount allocated pursuant to this subsection to increase or supplement the rates paid to skilled nursing care facilities for providing services pursuant to the state medicaid program, a rate adjustment shall first be made to reimburse the portion of the assessment imposed on medicaid patient days. The remainder shall be used to provide an increase to the rates in effect on July 1, 2008, paid to skilled nursing care facilities for providing services pursuant to the state medicaid program.
- (f) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the quality assurance fund interest earnings based on:
- (1) The average daily balance of moneys in the quality assurance fund for the preceding month; and
- (2) the net earnings rate of the pooled money investment portfolio for the preceding month.
- Sec. 5. If a skilled nursing care facility fails to pay the full amount of the quality assurance fee imposed pursuant to section 2, and amendments thereto, when due and payable, including any extensions of time granted

under that section, the secretary of aging shall assess a penalty in the amount of the lesser of \$500 per day or 2% of the quality assurance fee owed for the current fiscal year.

Sec. 6. (a) The secretary of aging shall assess and collect quality assurance fees imposed pursuant to section 2, and amendments thereto, including any penalty assessments imposed thereon pursuant to section 5, and amendments thereto, from skilled nursing care facilities on and after July 1, 2008, except that no fees or penalties shall be assessed under sections 1 through 6, and amendments thereto, until:

(1) An amendment to the state plan for medicaid, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of sections 1 through 6, and amendments thereto, is approved by the federal government; and

(2) the skilled nursing care facilities have been compensated retroactively at the increased rate for services provided pursuant to the federal medicaid program for the period commencing on and after July 1, 2008.

(b) The secretary of aging shall implement and administer the provisions of sections 1 through 6, and amendments thereto, in a manner consistent with applicable federal medicaid laws and regulations. The secretary of aging shall seek any necessary approvals by the federal government that are required for the implementation of sections 1 through 6, and amendments thereto.

(c) The provisions of sections 1 through 6, and amendments thereto, shall be null and void and shall have no force and effect if either of the following occur:

(1) The medicaid plan amendment, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of sections 1 through 6, and amendments thereto, is not approved by the federal centers for medicare and medicaid services; or

(2) the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program are reduced below the rates calculated on June 30, 2008, increased by revenues in the quality assurance fund and matched by federal financial participation.

Sec. 7. If the provisions of sections 1 through 6, and amendments thereto, are repealed or become null and void and have no further force and effect, all moneys in the quality assurance fund which were paid under the provisions of sections 1 through 6, and amendments thereto, shall be returned to the skilled nursing care facilities which paid such moneys on the basis on which such payments were assessed and paid pursuant to sections 1 through 6, and amendments thereto.

SB 585

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- Sec. 8. This act shall take effect and be in force from and after its
- 2 publication in the statute book.



AMERICANS FOR PROSPERITY

February 14, 2008

Chairman and Members of the Committee:

On behalf of the more than 13,000 Kansas members of Americans for Prosperity, we oppose SB 585.

This is yet another creative attempt to increase the Kansas tax burden.

This is a tax, no matter how folks want to describe it. It is a granny tax that will be passed on to a select few nursing home residents who were responsible enough to save for their later years to ostensibly benefit yet another small group of Kansans.

Since 2000, Kansas ranks 16th in Medicaid spending growth. That is higher than all of our neighbors except Oklahoma. We appear to be spending plenty on Medicaid.

I suggest this committee and the State begin to more thoroughly evaluate current Medicaid programs to see what is working and what is not working before embarking upon yet another scheme to increase funding to programs whose effectiveness hasn't been studied.

Sincerely,

AFP Kansas State Director

AL CSBZ

KANSAS TAXPAYERS NETWORK

P.O. Box 20050 Wichita, KS 67208 www.kansastaxpayers.com

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Testimony Opposing S.B. 585

By Karl Peterjohn, Executive Director

The legislation before you today would massively increase the cost of nursing care services to citizens who would need to come up with an additional \$4.75 per day or \$1,733.75 a year to reside in a Kansas nursing home. While this legislation is described as an assessment or fee, this actually appears to be much more like a tax on nursing home patients with their own private resources. Medicaid and certain other seniors would be exempt from this new tax.

There does not seem to be any visible benefit to the nursing home resident who will have to find the additional funds to pay for this new state imposed tax. Nursing home residents are by their very nature people who are in poor health and without the ability to generate additional income by going to work. In many cases their families are already struggling to pay the substantial bills that nursing home residency requires today. The additional revenue raised by this bill would be used to subsidize Medicaid recipients' bills.

Adding an additional state charge while a loved one is struggling to regain or even maintain a level of life is a pernicious new burden to add to these elderly, sick, and the most frail Kansans. These are the weakest people who are facing a new cost that appears by this legislation to be largely hidden from them by the way it is going to be imposed under this bill.

S.B. 585 appears to hide this additional cost by forcing the nursing home operator to be the tax collector for this additional state charge. This is another new unfunded state mandate onto this residential industry in Kansas. The private sector in Kansas lacks the home rule powers that local units have that often allows the local governments to avoid or evade the state's new mandates that are non uniform in Kansas law.

S.B 585 will make the nursing home industry serve as the tax collector for this new state tax burden. This is inappropriate too.

The creation of a new tax or all right, you can call it an assessment, is the worst type of way to show our responsible senior citizens who are in the twilight of their lives and see how they are treated in Kansas by our state government: badly.



To Chairman Dwayne Umbarger and Members of the Kansas Senate Ways and Means Committee

February 14, 2008

My name is Tom Williams, Chief Executive Officer for Asbury Park, a not-for-profit continuing care retirement community in Newton, Kansas, affiliated with the Kansas Area United Methodist Church. We have 80 nursing residents, 52 assisted living residents and approximately 100 elders living in independent living cottages on our campus.

As you may know, Oklahoma initiated a "bed tax" in 2000. I personally saw how this tax worked when I was an Adult Care Home Administrator in Oklahoma from 2001 to 2005.

Our private pay residents were very upset that they had to pay this extra cost. It also accelerated the speed of spend-down among private pay nursing residents, resulting in a larger population of individuals requiring and receiving Medicaid assistance sooner in their lives than if the bed tax had not been in effect.

Many of my colleagues still working in health administration in Oklahoma who originally supported the bed tax now want it to go away because:

1. The tax has gone up.

2. Their Medicaid reimbursement rates are not keeping pace with the tax.

3. Private pay residents and their families are more irate about it every year.

4. It requires more paperwork that isn't justified by the amount of return.

It is evident just south of our fair state that this type of tax burdens long-term care providers and residents, adding yet another layer of bureaucracy to the world's second most regulated business.

My personal concern is that SB 585 does not address accountability, to ensure that the homes receiving the increases apply the dollar increase to implement better care programs that would improve individual outcomes of their residents rather than simply allowing the dollar increase to boost the profit margins for the owners/operators. I find it interesting that the for-profit nursing homes and corporations are the long-term care organizations that repeatedly want to pass this type of legislation.

One of the reasons I returned to Kansas was because of the higher standards for care and respect for the frail elderly here. I ask you to question the wisdom of starting a bed tax in Kansas. I respectfully ask that you oppose Senate Bill 585.

Tom Williams

Thank you.

Asbury Park CEO

Voice: 316-283-4770 Fax: 316-283-4799 Asbury Park is a Ministry of the United Methodist Church. www.asbury-park.org

200 Southwest 14th Street Newton, KS 67114



Eastridge Skilled Nursing Facility

604 1st ~ Centralia, Kansas ~ 66415 785-857-3388 ~ Fax: 785-857-3349

To:

Senator Dwayne Umbarger, Chair and Members

Senate Ways and Means Committee

From:

Pam Bachman, Administrator

Date:

February 14, 2008

Please Oppose Senate Bill 585

Thank you Chairman Umbarger and Members of the Committee for the opportunity to testify regarding Senate Bill 585.

I am the Chair of the Board of the Kansas Association of Homes and Services for the Aging. I am also the Administrator of Eastridge Skilled Nursing Facility, a 41-bed facility in the rural community of Centralia, for the past 14 years. Eastridge was opened by the community in 1990. At Eastridge we take care of the frailest, oldest and most vulnerable people in our community.

On behalf of the KAHSA Board, and the residents at Eastridge and other small rural homes like ours, I ask you to oppose Senate Bill 585.

In my 14 years at Eastridge, I have seen many elders spend down their resources and become dependent on Medicaid. It is a very traumatic experience for them to have to turn to Medicaid to pay for their care needs. I understand this personally. My 97 year old grandmother had to turn to Medicaid in the last year of her life, after she paid for five years of nursing home care out of her own pocket.

Senate Bill 585 will speed up the process of depletion of many nursing home residents' private funds. If Senate Bill 585 passes, my facility will have to pay over \$57,000 in the first year for this tax, half of which will have to be passed directly on to residents who are paying for their own care. I will have to go to my residents and tell them that their nursing home bills are going up at least \$1700 a year. Plus, if Eastridge is offered a higher Medicaid rate under the bill, I would have to increase my private pay rates even more than \$1700 a year in order in order to accept the added Medicaid reimbursement. This is way more than our local market will bear and more than we should be asking of our private pay residents.

I don't want to tell Mrs. D, a 95 year old widow and retired school teacher who has lived with us for three years that her rates are going up to pay for Senate Bill 585. Until three years ago Mrs. D. was still living in her family home where she and her husband raised their 4 children. Her daughter had moved back from Colorado to care for her so she could stay at home. Only when the daughter's health failed did Mrs. D. turn to us for care.

I am also very disturbed to know that a good portion of the enhanced Medicaid rates that some nursing homes will receive could be used for profit rather than quality improvement.

I appreciate your attention to all aspects and potential consequences of this bill and thank you for the ability to speak to you today. I would be pleased to answer questions.

Together we're building healthy communities a division of Community Hospital Onaga, Inc.



"To Know, To Love, To Serve"

To: The Honorable Dwayne Umbarger and

Members of the Senate Ways and Means Committee

From: Tom Church, President/CEO, Catholic Care Center

Date: Wednesday, February 13, 2008

Testimony in Opposition to Senate Bill 585

Good morning, Mr. Chairman and Members of the Committee. Thank you for this opportunity to come before you and to share my deep concerns about Senate Bill 585.

My name is Tom Church and I am the CEO of the Catholic Care Center, the largest nursing facility in Sedgwick County. Sponsored by the Catholic Diocese of Wichita and the Via Christi Health System, we are licensed for 178 beds of skilled nursing and 120 beds of assisted living, 40 of which are a specialty Alzheimer center.

Both the American Health Care Association and its state affiliate, KHCA; and the American Association of Homes and Services for the Aging, and its state affiliate. KAHSA are proponents of quality of care for seniors. Both have subscribed to national initiatives known as "Quality First," and more recently, "Advancing Excellence in America's Nursing Homes," to ensure the provision of quality care the public expects.

The fact that one provider organization champions this legislation while the other unanimously opposes it would suggest minimally a matter of great caution. I believe both parties genuinely desire solutions to the significant funding issues we do and will have. The solutions proposed by this bill only create larger and greater problems.

As a not-for-profit faith based community we oppose SB 585 for the following reasons:

- As an advocate for a very frail and vulnerable population that is already shouldering the variance between the nursing facility Medicaid reimbursement rate and the private pay rate, the quality assessment fee, a misnomer for "provider tax" adds insult to injury.
- This bill would greatly accelerate the depletion of private pay resident's assets. At the proposed \$4.75 dollars per bed per day, the Catholic Care Center would pay over \$260,000 annually.
- As a long term care administrator I am obligated to be on the lookout for abuse, neglect and exploitation of the frail and sometimes cognitively compromised elders who reside with us. In my mind SB 585 raises the matter of financial exploitation as it will not provide better care for those from whom the funds are extracted.
- As a mission driven organization one has to ask, "Who are the beneficiaries of this proposal?" The fact that the "for-profits" are aligned for it and the "not-forprofits" against it is telling.

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TELEPHONE (316)744-2020

- While the bill purports to create a "quality assurance assessment fund," I see nothing in the bill that describes quality outcomes and improvements, perhaps because the bill is not really about quality.
- We must also ask what the likely and unintended consequences would be if this legislation were to be passed. Do we really need another administrative bureaucratic migraine? The administration of this fund is not at all as simple as described here. Do we really want to erode the dignity of elderly who saved for tough times by forcing them into indigence? Could we not rather come together with a proposal we both accepted and with one that made Kansas a model rather than a dunce? I think we can.

I respectfully ask this Committee to allow this misguided proposal to expire here.



To: Chairman Dwayne Umbarger and Members,

Senate Ways and Means Committee

From: Debra Harmon Zehr, President

Kansas Association of Homes and Services for the Aging

Date: February 14, 2008

TESTIMONY IN OPPOSITION TO SENATE BILL 585

Thank you, Chairman Umbarger and Members of the Committee.

The Kansas Association of Homes and Services for the Aging (KAHSA) represents 160 not-for-profit nursing homes, retirement communities, hospital long-term care units, assisted living facilities, senior housing and community service providers who serve over 20,000 older Kansans every day.

Senate Bill 585 is bad public policy.

Senate Bill 585 has been presented by proponents as a way to generate additional federal revenue for the state Medicaid program and to upgrade the quality of nursing home care. They also claim that very few nursing homes would be negatively impacted and that virtually no negative impact would be experienced by nursing home residents.

These two primary assertions are contradicted by an independent analysis of Senate Bill 585 conducted by economist and Medicaid rate setting expert Dr. Steve Lorenzen. Dr. Lorenzen was unable to be here today due to a prior commitment in Texas, but has provided written testimony. He wanted me to convey to you that he would be happy to appear before this Committee at a future date to explain his analysis and conclusions in more details and to answer questions.

Senate Bill 585 will cause inflationary pressure on nursing home private pay rates.

Nearly 7,400 elderly Kansas citizens pay for their own nursing home care every day. These individuals have exercised personal responsibility. They have scrimped and saved for decades so that they would be able to take care of their own health care needs in old age. The new tax imposed on nursing homes in Senate Bill 585 will cause many private pay residents' bills to go up \$1,700 a year. In some homes, it may be even more if the provider wants to accept their full "enhanced" Medicaid rate.

Senate Bill 585 will increase the State's Medicaid obligation.

By increasing the burden on private pay residents, Senate Bill 585 will hasten their dependence on Medicaid and increase the State's Medicaid obligation... even as stakeholders and experts universally agree that Medicaid is already growing at an unsustainable rate. As a State we need to encourage, not discourage, personal responsibility among those who are able.

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The future of provider taxes as a permissible way to increase federal match is in doubt. Many federal policymakers and regulators do not like provider taxes and would like to see them eliminated. Does Kansas really want to risk becoming dependent on a nursing home bed tax, only to be left holding the bag when the federal government discontinues participation?

Some nursing homes will "lose."

By federal law, the gains from the tax will not be distributed uniformly among all nursing homes, and there can be no guarantee that homes will be held harmless. In the case of Senate Bill 585, twenty nursing homes will pay more in taxes than they get back. And remember, even in many of the homes that "win," private pay residents are still losers.

Despite a lot of assertions to the contrary, Senate Bill 585 is not strictly about quality.

Some elements of the nursing home reimbursement methodology in Senate Bill 585 have nothing to do with quality, such as the removal of the 85% occupancy rule and the "cost efficiency" factor. Some others sound quality-focused, but the truth is that once the dollars are returned to the provider in the form of rate increases they do not have to be used for quality efforts. According to Dr. Lorenzen's analysis, as much as two thirds of the revenue generated for enhanced rates could to be diverted by providers with a strong profit motive for purposes other than quality improvement.

Senate Bill 585 may disrupt the State's progress toward balancing the long term care delivery system.

Another possible unintended consequence is that companies attracted by richer Medicaid funding in Kansas may queue up to build more nursing homes or add more nursing homes beds when we already have a surplus. This runs counter to the state's decade long movement to decrease nursing home beds and enhance community-based long term care options. It could short-circuit our ability to develop an integrated, well-thought out long-term care system.

I would also note that in a meeting of the Kansas Health Policy Authority Board in January, the staff of the Kansas Health Policy Authority, the Department on Aging and the health care accounting firm of Myers and Stauffer all alluded to many of the same concerns I have expressed here today. After their reports and discussion, the KHPA Board decided to take no definitive action on the nursing home bed tax concept.

In conclusion, I offer this quote from Dr. Lorenzen:

...provider taxes in general, and SB 585 in particular, fail to live up to the claims of proponents... provider taxes are inequitable as a method of financing Medicaid services... SB 585 lacks any assurance that funds generated by the tax will be used cost-effectively to enhance quality.... If I were a private investor in Kansas nursing homes, I would be pleased with the provider tax proposal.

KAHSA urges the Committee to oppose Senate Bill 585. It is bad public policy, riddled with potential negative short-term and long-term consequences for individual Kansans as well as the State.

Thank you. I would be pleased to answer questions.



Testimony on SB 585 Senate Ways and Means Committee Steve Albrecht, Regional Director of Government Relations, Golden Living February 14, 2008

Mr. Chairman and members of the Ways and Means Committee, my name is Steve Albrecht, Regional Director of Government Relations for Golden Living and I am submitting testimony in support of Senate Bill 585. Golden Living is a long-term care provider operating 18 Golden Living Centers in Kansas, employing approximately 1,000 people and proudly caring for 950 frail and elderly Kansas each and every day.

Golden Living operates some 350 nursing homes and assisted living facilities in 22 states and we are well aware of the many challenges facing legislatures across the country as they strive to address the needs and costs of Medicaid. In particular, nursing homes are seen as a major cause of increased Medicaid costs. But in reality, nursing home costs in many states have been growing significantly less than overall Medicaid costs due in part to rate reductions, rate freezes, or utilization of outdated cost reports that fail to accurately reflect the true and total cost of care.

Yet in Kansas, as in many other states, nursing home rates continue to see a widening gap between the cost of caring for residents in their nursing facilities and the rate they are paid by Medicaid. According to a recent study prepared by BDO Seidman, the shortfall in funding between the cost of care and rates paid in Kansas is \$60 million (\$14.97 per Medicaid patient day). This adds up to \$5,400 per year per Medicaid resident.

In Kansas you have an opportunity to address your Medicaid funding gap by passing SB 585. The nursing facility Quality Assurance Fee is a means by which new revenue can be generated to the state of Kansas through additional federal financial participation without requiring the commitment of additional general revenue funds that could impact the state budget. Golden Living has seen similar policies such as this work in other states, most recently in Indiana. Indiana's nursing facility fee has afforded Golden Living the opportunity to increase wages of employees and pursue capital improvements that are having a direct impact on the overall quality of life for our residents. And, the U.S. Congress recognized the importance and legitimacy of this type of funding policy when it passed bipartisan legislation in 2004 that places this policy in statute.

It is not uncommon for legislators to be concerned that a nursing home provider will absorb the cost of paying the assessment by increasing private pay rates. Golden Living's experience in states with similar provider fees is that we have not added the per day assessment amount to our private pay rates. In fact, we have found that the competitive market of long-term care keeps in check any sudden escalation of private pay rates, especially once providers see a decrease in the shortfall of Medicaid funding through enhanced rates from a fee such as proposed in SB 585.

At Golden Living we believe SB 585 will address funding needs not only specific to nursing homes but it can also assist Kansas Medicaid in supporting other necessary programs across the entire long-term care continuum.

On behalf of our residents and our employees I strongly urge you to vote in favor of SB 585.

Thank you for your time and consideration.

KHCA Homes

	С	W	AE
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2	Name	Total Net Return Provider Enhancement	Senate District
	Highland Care Center	21,624	1
	Infinia at Onaga, Inc.	69,503	1
	Medicalodge of Atchison	111,125	1
	Medicalodges Jackson County	58,081	1
	WATHENA NURSING & REHAB CEN	69,652	1
	Pioneer Ridge Retirement Community	23,981	2
	Baldwin Care Center	25,530	3
	Country Care Home	60,726	3
	Hickory Pointe Care & Rehab Ctr	169,912	3
	Tonganoxie Nursing Center	207,029	3
	Valley Health Care Center	86,329	3
	Lifecare Center of Kansas City	112,774	4
	Medicalodge East of Kansas City	120,876	4
	Medicalodge Post Acute Center	211,510	4
	Bonner Springs Nursing & Rehab	97,885	5
	Golden Living Center-Lansing	79,748	5
	Medicalodge of Leavenworth Edwardsville Manor	140,196	5
		306,647	6
	Golden Living Center-Kaw River Golden Living Center-Parkway	162,852	6
	PROVIDENCE PLACE	128,874	6
	Trinity Nursing & Rehab Ctr	(155,610)	6
	Garden Terrace at Overland Park	266,072	/
_	Overland Park Nursing & Rehab	50,765	8
	Delmar Gardens of Overland Park	159,727	8
	Sharonlane Nursing Home	242,117	9
	Shawnee Gardens Nursing Center	156,767	10
	Indian Creek Healthcare Center	267,912	10
	Specialty Hospital of Mid-America SN	190,850	11
	Anderson County Hospital	132,860 46,835	11
	Golden Heights Living Center		12 12
	Life Care Center of Osawatomie	78,718 232,198	
	Louisburg Care Center	65,389	12
	Medicalodge of Paola	378,570	12
	North Point Skilled Nursing Center	84,512	12
	Richmond Healthcare and Rehabilitati	45,566	12
	Galena Nursing & Rehab Center	104,468	13
	Golden Livng Center-Pittsburg	249,137	13
	Medicalodge North of Pittsburg	42,515	13
42	Medicalodge of Ft. Scott	139,542	13
	Medicalodge South of Pittsburg	110,425	13
	Sunset Manor, Inc	263,257	13
_	Applewood Rehabilitation	160,140	13
	Chetopa Manor	72,767	
	Heritage Health Care Center	90,987	14
	Medicalodge East of Coffeyville	87,357	14

KHCA Homes

	С	W	AE
2	Name	Total Net Return Provider Enhancement	Senate District
	Medicalodge of Columbus	81,967	14
	Quaker Hill Manor	150,846	14
	Howard Twilight Manor	25,641	15
	Cherryvale Care Center	122,617	15
	Golden Living Center-Fredonia	63,797	15
	Golden Living Center-Neodesha	79,966	15
	Life Care Center of Burlington	44,467	15
	Moran Manor	84,043	15
	Pleasant Valley Manor	178,435	15
	Regal Estate	59,129	15
	Golden Living Center-El Dorado	184,864	16
	Lake Point Nursing Center-Augusta	187,301	16
	Lakepoint Nursing Center-El Dorado	216,051	16
	Lakepoint Nursing Ctr-Rose Hill	82,077	16
	Life Care Center of Andover	104,215	16
	Medicalodge of Douglass	42,670	16
	Medicalodge of Eureka	168,382	16
	Chase County Nursing Home	82,724	17
	Council Grove Healthcare Center	97,530	17
68	Golden Living Center-Marion	118,749	17
69	Alma Manor	44,146	18
	Heritage Village-Eskridge	203,972	18
	IHS of Brighton Place	116,706	18
	Lexington Park Nursing and Post Acut	(26,304)	
	Rossville Healthcare & Rehab Center	95,142	18
74	Brookside Manor	75,146	19
	Countryside Health Center	110,420	19
	Eventide Convalescent Center, Inc.	272,077	19
	Osage Nursing & Rehab Center	44,046	19
	Peterson Health Care, Inc.	19,249	19
	Providence Living Center	192,922	19
	Topeka Community Healthcare Cente	253,539	
	McCrite Plaza Health Center	85,761	20
	Plaza West Care Center, Inc.	284,365	
	Rolling Hills Health Center	298,160	
	Cambridge Place	121,030	
	Community Care, Inc.	27,852	
	Golden Living Center-Wakefield	76,441	21
	Leonardville Nursing Home	99,198	
	Medicalodge of Clay Center	42,062	
	Sabetha Nursing Center	29,288	
	The Centennial Homestead, Inc.	46,921	
	Stoneybrook Retirement Community	168,220	
	Pinnacle Ridge Nursing & Rehab	255,657	
	Golden Living Center-Spring Hill	130,640	
94	Meadowbrook Rehab Hosp., LTCU	74,619	23

KHCA Homes

96 Center for LTC of Salina 111,714 97 Holiday Resort of Salina 69,693 98 Windsor Estates 62,930 99 Lakepoint Nursing and Rehabilitation 172,710 100 Medicalodge of Wichita 108,511 101 Meridian Nursing & Rehab Center 313,894 102 Haysville Healthcare Center 258,975 103 Medicalodge of Goddard 88,471 104 Westview of Derby 189,816 105 Golden Living Center-Wichita 169,167 106 Life Care Center of Wichita 91,491 107 Halstead Health and Rehab Center 259,020 108 Sedgwick Healthcare Center 91,360 109 Golden Living Center-Wellington 122,485 110 Medicalodge East Healthcare Center 72,549 111 Medicalodge North of Arkansas City 100,067 112 Riverview Manor, Inc. 68,258 113 Spring View Manor 127,371 114 Great Bend Health & Rehab Center 191,519 115 Medicalodge of Kinsley 84,821 116 Woodhaven Care Center 42,325 117 Golden Plains 223,852 118 Chapman Valley Manor <th></th> <th>С</th> <th>W</th> <th>AE</th>		С	W	AE
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124 Wheatridge Park Care Center (1,545)				36
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125 Homestead Health & Rehab 29,441		Homestead Health & Rehab		39

KAHSA Homes

	С	W	AE
2	Name	Total Net Return Provider Enhancement	Senate District
130	Atchison Senior Village	77,070	Jenate District
	Community Hospital of Onaga, LTCU	84,342	1
	Dooley Center	137,017	1
	Valley Vista Good Samaritan Center	34,303	1
	Lawrence Presbyterian Manor	2,649	2
135	Eudora Nursing Center	83,359	3
136	Kansas City Presbyterian Manor	310,803	5
137	SOMERSET-CLARIDGE COURT	(60,515)	
	Johnson County Nursing Center	275,354	9
139	Lakeview Village	(61,533)	
140	Villa Saint Joseph	71,104	11
	Village Shalom, Inc.	49,696	11
	Prescott Country View Nursing Center	30,141	12
143	Cornerstone Village, Inc.	130,655	13
	Parsons Good Samaritan Center	72,232	14
	Parsons Presbyterian Manor	18,750	14
146	Prairie Mission Retirement Village	42,082	14
147	Wheat State Manor	59,517	16
	Coffey County Hospital	30,182	17
	Emporia Presbyterian Manor	22,511	17
150	Parkside Homes, Inc.	58,360	17
	St. Luke Living Center	9,068	17
152	Topeka Presbyterian Manor Inc.	142,950	
	Aldersgate Village	1,021,673	18
	Brewster Place	(35,082)	20
	Apostolic Christian Home	64,227	
156	Clay Center Presbyterian Manor	7,187	21
157	Frankfort Community Care Home, Inc.		21
158	Great Plains of Republic County, Inc	57,954	21
159	Jewell County Hospital	23,808 15,524	21
_	Linn Community Nursing Home		21
	Sunset Home, Inc.	37,697	21
162	Junction City Good Samaritan Center	19,250	21
163	Meadowlark Hills Retirement Commun	95,452	22
	St. Joseph Village, Inc.	1,413	22
	Aberdeen Village, Inc.	272,088	22
	Olathe Good Samaritan Center	(5,155)	
	Minneapolis Good Samaritan Center	284,467	23
168	Salina Presbyterian Manor	91,435	24
	Village Manor	(25,793)	
	Homestead Health Center, Inc.	70,110	24
	Kansas Masonic Home	110,029	25
	Wichita Presbyterian Manor	125,571	25
		3,445	25
174	Cheney Golden Age Home Inc.	90,799	26
	Mt. Hope Nursing Center	90,495	26
1/3	The Health Care Center@Larksfield P	(83,691)	30

KAHSA Homes

	С	W	AE
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2	Name	Total Net Return Provider Enhancement	Senate District
_	Asbury Park	119,272	31
	Bethel Care Center	21,263	31
	Catholic Care Center Inc.	44,135	31
	Kansas Christian Home	102,238	31
-	Newton Presbyterian Manor	53,894	31
	Schowalter Villa	133,919	31
	Arkansas City Presbyterian Manor	3,937	32
	Slate Creek Good Samaritan Center	36,306	32
	Villa Maria, Inc.	80,536	32
	Winfield Good Samaritan Center	127,071	32
	Anthony Community Care Center	123,960	33
	Ashland Health Center - LTCU	16,324	33
	Attica Long Term Care	48,649	33
	Kiowa Hospital District Manor	66,167	33
	Leisure Homestead at St. John	16,548	33
	Leisure Homestead at Stafford	27,082	33
	Pioneer Lodge	35,851	33
	Protection Valley Manor	52,421	33
	The Wheatlands	39,442	33
	Buhler Sunshine Home, Inc.	98,765	34
	Hutchinson Good Samaritan Village	136,027	34
	Mennonite Friendship Manor, Inc.	136,207	34
	Prairie Sunset Manor	52,368	34
	Ray E. Dillon Living Center	80,952	34
	Wesley Towers	65,634	34
	Bethany Home Association	15,742	35
	Bethesda Home	61,534	35
	Ellsworth Good Samaritan Ret. Villag	53,336	35
	Lyons Good Samaritan Center	74,283	35
	Memorial Home for the Aged	36,067	35
			35
	Moundridge Manor, Inc. Pleasant View Home	171,731	35
	01 - 10 pc - 1	137,764	
	Riverview Estates, Inc.	40,672	35
	Sandstone Heights	. 48,263	35
	Sterling Presbyterian Manor	43,806	35
	The Cedars, Inc.	118,086	35
	Ellis Good Samaritan Center	29,068	36
	Great Plains of Mitchell County, Inc	16,651	36
	Hays Good Samaritan Center	140,777	36
	Logan Manor Community Health Serv	37,247	36
	Phillips County Hospital LTCU	(3,537)	
	Phillips County Retirement Center	72,655	36
	Rush County Nursing Home	74,939	36
	St. John's of Hays	64,741	36
	St. Johns Victoria	102,693	36
221	St. Joseph Memorial Hospital	17,749	36

KAHSA Homes

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5			
2	Name	Total Net Return Provider Enhancement	Senate District
222	Villa St. Francis	146,333	37
223	Bethel Home, Inc.	80,829	38
	Dodge City Good Samaritan Center	152,774	38
225	Fowler Nursing Home	6,193	38
	Hill Top House	49,164	38
227	Liberal Good Samaritan Center	124,976	38
228	Manor of the Plains	23,965	38
229	Mead District Hospital, LTCU	60,168	38
230	Minneola District Hospital	22,845	38
	The Shepherd's Center	12,665	38
232	Trinity Manor	130,959	38
233	Garden Valley Retirement Village	157,481	39
	High Plains Retirement Village	44,686	39
	Morton County Hospital	81,492	39
236	Pioneer Manor	104,023	39
237	Satanta Dist. Hosp. LTCU	38,977	39
	Seasons of Life Living Center	18,570	39
	Stanton County Hospital- LTCU	16,870	39
	Western Prairie Care Home	79,508	39
241	Andbe Home, Inc.	37,143	40
	Atwood Good Samaritan Center	10,766	40
	Dawson Place, Inc.	69,538	40
	Decatur Co. Good Samaritan Center	12,336	40
	Gove County Medical Center	29,181	40
	Greeley County Hospital, LTCU	14,635	40
	Lane County Hospital - LTCU	(2,861)	40
	Logan County Manor	32,732	40
249	Park Lane Nursing Home	43,048	40
	Prairie Manor Good Samaritan Center	21,877	40
	Prairie Senior Living Complex	76,154	40
	Rooks County Senior Services, Inc.	27,582	40
	Sherman Co. Good Samaritan Center	83,566	40
	Solomon Valley Manor	32,336	40
	St. Francis Good Samaritan Ctr	70,040	
	The Lutheran Home - Wakeeney	45,703	40
	Trego Co. Lemke Memorial LTCU	(1,858)	40
258	Wichita County Health Center	(6,136)	40

Non KHCA KAHSA Homes

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263 Maple Heights of Hiawatha 223,533 264 Oak Ridge Acres 189,314 265 Tif County Manor Living Center, Inc. 124,119 266 Westy Community Care Home 317,718 267 BRANDON WOODS RETIREMENT C (108,191) 268 Jefferson Co. Memorial Hospital-LTCU 101,965 269 Village Villa 121,254 270 LAWRENCE MEMORIAL HOSPITAL 139,034 271 LAYRENCE MEMORIAL HOSPITAL 139,034 272 THE FORUM AT OVERLAND PARK (117,878) 273 Delmar Gardens of Lenexa 3,990 274 Hillside Village 135,691 275 THE SWEET LIFE AT ROSEHILL (182,767) 276 Manoracra Hith Services of Overland 168,097 277 Ottawa Retirement Village (34,523) 278 Wellsville Manor 43,430 279 Arma Care Center 32,749 280 Emerald Pointe Health & Rehab Cent 734,567 281 Fort Scott/Marmaton Valley 38,414				
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268 Jefferson Co. Memorial Hospital-LTC			317,718	1
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309 Crestview Manor 17,471				21

Non KHCA KAHSA Homes

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2	Name		Senate District
310	Eastridge Nursing Home	8,714	21
311	Life Care Center of Seneca	151,421	21
312	Mt Joseph Senior Community, Inc.	329,220	21
313	Park Villa Nursing Home	149,076	21
	The Nicol Home, Inc.	94,377	21
315	Valley View Professional Care Center	(19,385)	22
316	Royal Terrace Nrsg. & Rehab. Center	239,876	23
317	Great Plains of Ottawa County, Inc.	213,561	24
318	Kenwood View Nursing Center	334,838	24
319	Smokey Hill Rehabilitation Center	87,057	24
321	Via Christi Hope-PACE	25,372	25
	RIVERSIDE VILLAGE INC	(11,935)	25
	Clearwater Ret. Community, Inc. dba	(27,921)	26
	Lakewood Senior Living of Seville	9,964	27
325	PARK WEST PLAZA	(125,368)	
326	Sandpiper Bay Health & Retirement C	131,961	27
327	Abal Home	56,427	28
328	College Hill Nursing and Rehab Cente	(12,180)	
329	Infinia at Wichita	48,491	30
330	Manorcare Health Services of Wichita	(17,691)	30
	Cumbernauld Village, Inc.	294,567	32
	Dexter Care Center	1,783	32
	Winfield Rest Haven, Inc.	12,947	32
	SUMNER REGIONAL MEDICAL CEN	346,355	32
	WILLIAM NEWTON MEM HOSPITAL	10,436	32
337	Cherry Village Benevolence	273	33
	Friendship Manor of Pratt	176,468	33
	Friendship Manor Rehab Ctr of Havila	112,075	33
	Hilltop Manor	(40,606)	33
	Infinia at Hutchinson	14,830	34
	HUTCHINSON HOSPITAL SNF	146,866	34
	Cheyenne Meadows Living Center	(28,853)	35
	Enterprise Estates Nursing Center, I	(7,875)	35
	Infinia at McPherson	157,339	35
	Mid-America Health Center of Lincoln	49,981	35
	Hilltop Lodge Nursing Home	. 143,797	36
	Hodgeman Co Health Center-LTCU	95,726	36
	Infinia at Kensington	80,661	36
	Infinia at Smith Center	417,608	36
	Larned Healthcare Center	90,225	36
	Parkview Care Center	33,606	
	Rush Co. Memorial Hospital	(14,250)	
	Russell Regional Hospital	(20,805)	
	Smith County Memorial Hospital LTCL		
	WESTERN PLAINS MEDICAL COMP		
	SOUTHWEST MEDICAL CENTER SI		
357	1900 I HANEST INIEDICAL CENTER SI	(31,122)	71 30

Non KHCA KAHSA Homes

	С	W	AE
	*		
2	Name	Total Net Return Provider Enhancement	Senate District
358	Decatur County Hospital	(32,015)	40
	Grisell Memorial Hosp Dist #1-LTCU	(17,822)	40
	Infinia at Colby	(42,999)	40
	Ness County Hospital Dist.#2	(39,482)	40
	Sheridan County Hospital	(36,091)	40
363	HOEGER HOUSE	(29,474)	



Written Testimony on Senate Bill 585
Submitted by Tom Akins, Vice President for Development and Planning
February 14, 2008

Thank you for the opportunity to present written testimony in opposition to Senate Bill 585.

Why in the world would the State of Kansas turn down "free" money? On the surface, Senate Bill 585 would seem to beg this question. A deeper examination of the bill and its consequences, however, reveals that it is not the role of the state government to tax some of its citizens so as to provide additional money for others of its citizens *merely* because it can. The question before us today should be: does this legislation represent sound public policy that enables the provision of quality care? I would argue that Senate Bill 585 does not for two reasons.

• First, there is no mechanism in the bill that mandates how increased monies received by skilled nursing facilities must be spent. If the goal of this particular piece of legislation is to improve quality within skilled nursing facilities, the Secretary must have some basis to judge whether or not quality actually improved as a result of increased expenditures. Absent any benchmarks, facilities would be able to do exactly what this legislation precludes the state from doing: namely, shifting resources internally to replace expenses related to skilled care (Section 4, F, 2). Nothing in this legislation would preclude a facility

from making adjustments internally and using the increased allocation for programs outside the scope of "maintaining or improving the quantity and quality of skilled nursing care..." A recently completed study documents the fact that in its current form, more than half of monies returned to skilled nursing facilities by this legislation could be diverted to pure profit. Is it really the intent of this committee to tax some of its citizens in order to leverage federal dollars merely to provide a return to private investors? Everyone – not-for-profit and for-profit facilities alike – can agree on the fact that improving quality of care is a goal we all strive for. *Nothing in this bill measures, mandates, or monitors* any aspect of improved care in skilled nursing facilities in this state.

• Second, if we do nothing to change the current national system of financing long-term care, unsustainable pressure on state budgets and Medicaid will lead to either abandoning all other state responsibilities, such as education, or abandoning ever-larger proportions of those with long-term care needs. The stark reality is this: Medicaid costs for long-term care will double by 2025 and increase five-fold by 2045. This legislation, at its core, does more than simply ignore this reality; it communicates that we're going to grab every bit of money we can without regard to how much more quickly it will push our current system to ruin. The legislation in its current form presents more than just a moral dilemma. If the federal government at some point down the road decided for whatever reason to disallow this type of program, the State will have to cut rates or make up the difference (Section 7).

To: Chairman, Dwayne Umbarger Senate Ways and Means Committee

From: Jennifer Gillespie, Adm./CEO, Leisure Homestead Association

Stafford and St. John

Date: Wednesday, February 13, 2008

PLEASE VOTE NO ON SENATE BILL 585

Thank you for the opportunity to provide written testimony regarding SB 585.

I have been the Administrator of Leisure Homestead Association now for thirty years. As you know, we have a small 50 bed facility in Stafford and a 30 bed facility in St. John. At Leisure Homestead we take care of the frailest, oldest and most vulnerable people in our communities.

I ask you to vote 'No' on Senate Bill 585.

At both of our facilities, a little less than half of our residents are receiving Medicaid. I understand that many facilities have a much higher percentage of residents receiving Medicaid. We try to watch our spending in order to keep our room rates as low as possible and yet provide quality care. We have been able to do this as evidenced by receiving only 2 deficiencies on our last survey with no deficiencies in nursing.

Senate Bill 585 will speed up the process of depletion of private funds to pay for nursing home care. The impact of the tax could be \$1,700 or more for private pay residents in nursing facilities across the state and will hasten their dependence on Medicaid and increase costs to the State. Experts agree that Medicaid is already growing at an unsustainable rate.

The bill does not guarantee that the money will be used for quality. As a small rural nursing home, we will find it hard to survive if we do not get the amount we pay in tax returned since we barely break even now. Any additional expense could be devastating to our small free-standing facilities. Any extra tax burden will push small homes out of business and residents will have to move away from family and friends and there won't be jobs for the employees.

It troubles me that this bill is being supported by the for-profit providers of Kansas. An independent expert identifies that nearly two-thirds of the money that could go towards nursing home Medicaid payment under the bill could be pocketed by nursing homes with a strong profit motive (which we certainly don't have) instead of being used to enhance quality of care.

I believe Senate Bill 585 is bad public policy, with many negative consequences waiting to happen.

I appreciate your attention to all aspects and potential consequences of this bill and ask you to vote 'No'.



1156 Highway 14, Ellsworth, KS 67439 Tel: 785-472-3167 FAX 785-472-5440

Management Staff

Administrator: Dr. Jim Morford

Office Manager Linda Vague

Nursing Services Betty Slagle-Hoosier, RN

Senior Housing, and Human Resources Georgina Bates

Dietary Services Virginia Kootz

Environmental Services Randy Moon

Prairie West Assisted Living Margaret Long

Social Services Nancy Bircher

Activities Bobbie Jones

Health Information Lori McQueary

Rehab Services, Judy Fuller

Laundry Services, Dianne Long

MDS Coordinator Peggy Benavidez Date: February 14, 2008

To: Chairman Dwayne Umbarger & Members of the Senate Ways and Means Committee From: Jim Morford, Administrator, Good Samaritan Society-Ellsworth Village

Opposition to Senate Bill 585

Thank you for this opportunity to share my perspective on Senate Bill 585. I am Jim Morford, Administrator of Good Samaritan Society-Ellsworth Village. Our Village consists of senior housing, congregate living, assisted living, skilled nursing and one of three stake holders in a home health agency ... all in a rural setting.

Senate Bill 585: Bad policy, bad message, bad motive ... it's just that simple.

Frail elders in our state never intended for their life's journey to include a nursing home stay. Folks need our care because of a myriad of reasons. Senate Bill 585 will punish many who have worked so hard to have enough in their "golden years." It isn't just that frail elders with some resources will deplete their resources more rapidly and need Medicaid assistance sooner than anticipated, (which will only increase the tax burden for the state), it's an issue of public policy and sensible taxation by our state.

It is of curious concern that the proponents of this bill are all for-profit entities. Could it be that they have a vested interest in this bill, and that is why they have included provisions so that two-thirds of all money which comes back can be ear marked as "profit" at the discretion of individual providers?!

My residents and their families who are "private pay" on my campus have enough concerns in trying to figure out how to pay for nursing home care, but to add this additional burden on them is to add insult to injury!

Please, please, realize how crazy this bill is, and what a horrible message it sends to all elder Kansans. "We'll get more of your money any way we can ... and when you're weak, we've ever got a good way to get more of your assets" Remember, Senate Bill 585 will make Kansas more dependent on the federal government. Many even at a national level are questioning this method of funding, so if the federal government finally ends this senseless program, the state would be in even a more difficult position of trying to make up for lost matching funds.

You, as our legislators, are charged with creating sound public policy and doing all you can to insure we protect our elders. Please vote NO on Senate Bill 585 and let Kansas continue to send a voice to the nation that this form of taxing our elders, and depleting their hard earned assets, just because they needed nursing home care, is bad!

Thank you for your thoughtful consideration in this matter.



To: Members of the Senate Ways and Means Committee

From: David Randazzo, Executive Director, Claridge Court (1)

Date: Thursday, February 14, 2008



Testimony in Opposition to Senate Bill 585

Good Morning, Members of the Committee. Thank you for this opportunity to come before you today to share my deep concerns about Senate Bill 585.

My name is David Randazzo and I am the Executive Director of Claridge Court, a continuing care retirement community located in Prairie Village, Kansas. We are licensed for 135 Apartments and 35 skilled nursing beds. My understanding is that, unlike the two veterans homes, Claridge Court would not be exempt from the provider tax as proposed in SB 585.

As a not-for-profit continuing care retirement community we oppose SB 585 for the following reasons:

- The new tax will be paid by the nursing home... but we all know that business taxes are passed on to the customer. This bill would accelerate the depletion of our private pay resident's assets. At \$4.75 per bed per day, Claridge Court would pay approximately \$60,000 in taxes annually for a small 35 bed facility.
- As a long term care administrator I am obligated to be on the lookout for abuse, neglect and exploitation of the frail elders who reside at Claridge Court. In my mind, SB 585 raises the question of exploitation, because there is no benefit for our residents as we do not participate in the Medicaid program.
- The Statewide for-profit nursing home association is in favor of Senate Bill 585.
 It is not surprising why, as nearly two-thirds of the money that could go toward increasing nursing home Medicaid payments under the bill could be pocketed by nursing homes with a strong profit motive, instead of being used to enhance quality of care.

At Claridge Court we pride ourselves in providing the best possible care for our residents on a financially sound basis. We are committed to doing the right thing for the right reasons and this bill just does not ring true on either count. Senate Bill 585 targets our frailest, oldest and most vulnerable people in our community. I respectfully ask this Committee oppose Senate Bill 585. Thank you for your consideration.

8101 MISSION ROAD PRAIRIE VILLAGE, KANSAS 66208 (913) 383-2085

LCRC



2800 Willow Grove Road Manhatran, KS 66502 Tel 785-539-7671 Fax 785-539-9125

Via Christi Health System February 12, 2008

Re: Senate Bill 585

Nursing Home Bed Tax Will Hit Frail Elders

I am writing this letter because I am opposed to Senate Bill 585. I feel this way for the following reasons:

It will cause a significant financial burden on private pay residents. The impact of the tax could be \$1,700 or more for private pay residents in many nursing facilities across the state! During this time of financial hardship, as evidenced by a plummeting housing market and slow economic growth, it's difficult to ask consumers to hand over more of their own money.

It's short-sighted, poor public policy. Senate Bill 585 sends the wrong message to Kansans about exercising personal responsibility in planning ahead to pay for their own long term care needs. Increasing the burden on private pay residents will hasten their dependence on Medicaid and increase costs to the State. As reported by Weiner, Sullivan, and Skaggs (1996), "as many as half of nursing home residents who are admitted as private pay patients run out of funds during their stay and become Medicaid beneficiaries". Over time this becomes cyclical and increasing in intensity, we exacerbate the spending demands on consumers creating dependence on Medicaid programs, and then wonder why Medicaid spending spirals out of control. Georgetown University's Long-Term Care Financing Project argues that "Medicaid is the nation's largest source of financing for long-term care, accounting for 49 percent of long-term care spending in 2005."

Lastly, the bill does not guarantee that the money will be used for quality. In fact, nearly two thirds of the dollars that might be returned to nursing facilities under Senate Bill 585 could be diverted to pure profit, rather than improvement of care and services. (This is according to Economist/Medicaid expert Dr. Steve Lorenzen) Why would we knowingly provide more dollars to increase for-profit corporation's shareholder value, while consequently subordinating quality care in our long-term care facilities? If the government truly cares about its spending and wishes to be responsive to the needs of its citizens it will not pass SB 585.

Respectfully Yours,

Ryan Grace Ryan Grace

Administrator St. Joseph Village

Manhattan, KS

A not-for-profit corporation jointly sponsored by the Sisters of the Sorrowful Mother and the Sisters of St. Joseph of Wichita



Parsons

February 12, 2008

Senator Dwayne Umbarger, Chair and Members of the Senate Ways and Means Committee,

Please Stop Senate Bill 585!

Good Day. Thank you for the opportunity to come before you to express my concerns about this piece of legislation.

I am Wade Gushee, Executive Director of the Presbyterian Manor of Parsons, Kansas. Our facility is a small not-for-profit Continuous Care Retirement Community with a 43 bed skilled nursing unit.

As a not-for-profit faith based community we oppose this piece of proposed legislation for the following reasons:

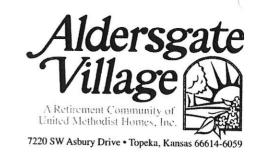
As an advocate of the Kansas elderly requiring nursing care already carrying the disparity between Medicaid and private funds, this tax would be adding to that burden.

This burden would accelerate the depletion of funds the folks paying for their own care have to work with.

As a mission driven organization I have to wonder at a proposed bill that has profitability as the polarization around support, with for-profits on the aye side and not-for-profits on the nay side.

The bill is, in part, to "improve the quality and quantity of nursing care". How does the legislation guarantee this to be the case? I see no specific verbiage that gives assurances in support of this position.

If we have a commitment to our frail and elderly, as we should, this bill is not a step in the correct direction. We at Presbyterian Manors of Mid-America, believe that no person should be denied the benefit of quality health care in an environment they are comfortable to call home without discrimination as to race, creed, sex, nationality or ability to pay.



To:

Senate Ways and Means Committee

From:

Jerry C. Ney, CEO; Aldersgate Village

Subject:

Stop Senate Bill 585

Date:

2.1.08

Testimony in Opposition to Senate Bill 585

Members of the Committee;

Let me get straight to the point: Stop Senate Bill 585

I am Jerry Ney, CEO of one of the largest retirement communities in Kansas.

Aldersgate Village Retirement Community is a not-for-profit continuing care retirement community located at 7220 SW Asbury Drive in Topeka, Kansas. Aldersgate Village offers 176 independent living units, including apartments, garden homes & cottages, 60 assisted living units and a 209-bed skilled nursing center including secured dementia neighborhoods. United Methodist Homes, Inc., DBA Aldersgate Village, has a 100+ year tradition of serving seniors.

As a not-for-profit continuing care retirement community, we oppose SB585 for the following reasons.

- This bill would accelerate the depletion of critical funds from private pay residents and more rapidly put them on the Medicaid roles of the State. These private pay residents are already subsidizing the Medicaid residents and any additional tax is excessive. It will cause a significant financial burden on private pay residents.
- The impact of the tax could be approximately \$1,700 or more for private pay residents in my facilities.
- Senate Bill 585 discourages Seniors to take personal responsibility in planning ahead to pay for their own long term care needs.
- Additional taxes like this will encourage more elderly to shelter their income increasing the pressure on private pay residents.
- A nursing home tax simply shifts costs from one pocket to another. And, it concentrates a disproportionate
 amount of the burden on one specific small group of people (elderly who need nursing home care and pay for it
 themselves.)
- Senate Bill 585 will increase state reliance on Medicaid at a time when all the experts agree that Medicaid is already growing at an unsustainable rate.
- The bill does not guarantee that the money will be used for quality. In fact, nearly two thirds of the dollars
 that might be returned to nursing facilities under Senate Bill 585 could be diverted to pure profit, rather than
 improvement of care and services. (This is according to Economist/Medicaid expert Dr. Steve Lorenzen of the
 University of Texas.) Some nursing homes lose. Dr. Lorenzen estimates that 20 providers will pay more in taxes
 than they get back.

Senate Bill 585 is short-sighted, poor public policy.

I respectfully ask this committee to oppose Senate Bill 585.

Sincerely,

Jerry C. Ney

CEO, Aldersgate Village

Lorenzen & Associates

TO:

Dwayne Umbarger, Chair and Members

Senate Ways and Means Committee

FROM:

Stephen A. Lorenzen, Ph.D.

DATE:

February 14, 2008

SUBJECT:

Testimony - Senate Bill 585

My name is Stephen Lorenzen and I am an independent consultant specializing in nursing facility and hospital reimbursement systems. I am unable to appear before you today due to a previous commitment that I was unable to reschedule, but I would be happy to appear personally at another time. I apologize for my absence and I thank the committee for the opportunity to submit written testimony on this important issue. I am submitting this testimony at the request of the Kansas Association of Homes and Services for the Aging (KAHSA).

My previous employment included serving as director of rate-setting for the various Texas Medicaid programs, including nursing facilities. In that role I was involved with provider tax issues from the time the current federal regulations were developed in the early 1990s. Since that time, provider taxes, sometimes euphemistically referred to as "assessments" or "Quality Assurance Fees," have been utilized by some 30 states. I have reviewed the different taxing and spending proposals introduced in a number of those states—some of which were adopted and others which were rejected.

Not unlike provider taxes in other states, the Kansas proposal, SB 585, has been presented by proponents as essentially an opportunity to generate a *federal revenue windfall* that could be used to increase Kansas Medicaid nursing facility rates for the purpose of *upgrading the quality* of nursing facility services in the state. And, proponents claim, all of these benefits would be realized with *negative impacts on very few providers* and *virtually no negative impact on residents*. As a result, it seems reasonable to judge SB 585 based on the extent to which two key objectives are likely to be realized—that the tax will be an equitable method of Medicaid finance and that enhanced quality of care commensurate with increases in public funding will result.

The reality of provider taxes is that they do seem to generate a federal revenue windfall. That is why the federal authorities consciously designed the provider tax Medicaid regulations to discourage the use of these taxes through built-in features that penalize some residents and/or homes. Thus provider taxes act as a 'double-edged sword' that *permits* a state to cut its relative share of Medicaid financing costs to a limited degree, but at the same time *prohibits* a state from directly off-setting losses to those residents or homes that would be unfairly penalized by the tax. For Medicaid residents, provider taxes are simply a cost pass-through to the federal government, via Medicaid rates, that is largely irrelevant to their lives. To private-pay residents, provider taxes often represent an additional drain on savings used to finance their care, causing them to spend down their own resources and become Medicaid eligible at a faster rate.

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residents, sometimes even suggesting that such a tax pass-through could be legislatively prohibited. Of course, legislation may prohibit itemizing taxes as part of nursing facility resident billing. However, prohibiting operators from increasing private rates over time to reflect increases in a wide variety of costs, including staff wages, food costs and provider taxes, is unrealistic.

Provider tax advocates tend to describe a kind of idealized world where virtually all nursing home residents are Medicaid eligible. In this case there would be no private-pay residents whose rates could be increased. However, in the real world in which we live, there are many nursing home residents who have worked hard, saved their money and are now struggling to pay their own nursing home bills. For these nursing home residents, a provider tax is a transfer of wealth from those who have worked and saved, to the state. In many cases, private-pay residents being taxed are only slightly better off financially than the Medicaid residents they are being forced to subsidize. Such a transfer would be unfair even if it impacted only 1% or 2% of nursing home residents.

In Kansas about 37% of nursing home residents are paying their own nursing home bills. This amounts to approximately 7,400 individuals on an average day. The annual cost of a \$4.75 tax per day of service on all private-pay residents in licensed nursing facilities would total approximately \$12.8 million. More to the point, the cost of a \$4.75 tax per day per individual resident would total some \$1,734 per year or about \$144.50 per month. Considering that the average Social Security cost-of-living increase for 2008 was 2.3%, this represented, at the average benefit for an aged widow or widower alone, a monthly increase of \$24--from \$1,017 to \$1,041--or less than \$1 per day.

Some of these private-pay residents are in homes with few Medicaid residents. In these homes the tax burden will fall on the residents themselves, either as a tax pass-through or in the guise of decreased services to bring after-tax costs into line with after-tax revenues. In other homes with a large majority of Medicaid residents, the tax on private-pay days of service may be absorbed by diverting funds nominally targeted toward enhanced quality. In other words, not only is the provider tax unlikely to be a painless way to raise revenue, much of the federal revenue generated by the tax is likely to be diverted for purposes other than those touted by tax proponents.

SB 585 which would change the Kansas Medicaid rate methodology is notable for the lack of any accountability for actually spending the proposed new funding for the stated purposes. The flexibility to divert funding from nominal targets is often a major attraction to proponents of provider taxes. Some measures, such as eliminating the rate adjustment for low occupancy—a measure that would reward inefficiency—and introducing an additional incentive for containing certain overhead costs, are straightforward measures that would tend to increase profitability. SB 585 includes an increase in the direct health care cost component of rates, to be achieved by adding 2% to the inflation adjustment of these costs. This measure is nominally directed toward quality enhancement, but includes no contractual requirements on the part of nursing homes receiving this revenue windfall that these funds would actually be expended to enhance direct care staffing or to increase wages or employee benefits for those staff.

The single largest component of the rate methodology proposal deals with a Fair Rental Value (FRV) payment that would replace payments based on historical costs of individual facilities. These FRV payments are based on general replacement costs of construction across the state. The selling point here has been that the tens of millions of dollars in increased Medicaid nursing facility funding resulting from implementation of the FRV would increase provider incentives to

rade and/or replace aging nursing facilities. However, SB 585 includes no standards or requirements to assure that this funding would be expended for the stated purpose. The funding would simply be available if individual providers chose to expend it in this fashion.

In recent years a number of states have been drawn to provider taxes in somewhat desperate budgetary circumstances and support for provider taxes is understandably greater in cases where the only alternative has been to do without rate increases, sometimes for several years. In this respect Kansas is an interesting case in that the rate methodology is relatively well designed to cover reasonable costs of most facilities and includes financial rewards linked to characteristics associated with quality. Under these circumstances, if the advocates of a provider tax are truly dedicated to accomplishing the goals they have described, they should not object to relatively strict accountability for expending the added funds for the stated purposes. In the absence of such accountability, many homes will divert a significant part of this funding to enhance earnings rather than direct care staff or the physical environment.

SB 585 would, at least nominally, target over 40% of the new funding toward remodeling or rebuilding nursing facilities. Although this may be a worthy goal, if the state is to fund this reconstruction effort it would seem reasonable to expect that the state would first define what types of reconstruction it is willing to pay for, how much it is willing to pay, and what level of accountability it expects for the funds to be expended. Under current circumstances, simply increasing Medicaid nursing facility rates in the hope that most providers would "do the right thing" and spend most of the funding on state-of-the-art facilities, staffing or other quality enhancements is unrealistic. Moreover, even providers who rebuild older facilities may be, in some cases, rebuilding facilities on an antiquated model.

All of these drawbacks to SB 585 are compounded by the fact that only 80 percent of the tax proceeds are to be devoted to the nursing facility program. Moreover, once the rate formulas are modified to build in the rate increases to be funded by the tax, the new level of rates may become a future state liability. Pressure at the federal level to reduce or eliminate the use of provider taxes seems unlikely to disappear. If opponents of the tax were to prevail in coming years, states with provider taxes would be faced with the difficult choice between sharply cutting Medicaid rates and increasing tax revenues from other sources.

My conclusion is that provider taxes in general, and SB 585 in particular, fail to live up to the claims of proponents. First, provider taxes are inequitable as a method of financing Medicaid services. Second, SB 585 lacks any assurance that funds generated by the tax will be used cost-effectively to enhance quality. In the spirit of windfall gains, the proponents appear to be proposing that the federal matching funds generated by the tax be distributed with no apparent strings attached. If I were a private investor in Kansas nursing homes, I would be pleased with the provider tax proposal. However, from the standpoint of cost-effective expenditure of public funds to purchase Medicaid nursing home services, I can only offer the simple warning, "Buyer Beware."

I would be pleased to meet with the Ways and Means Committee to answer any questions or provide further information.

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