Approved: March 16, 2011
Date

MINUTES OF THE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Vicki Schmidt at 1:30 p.m. on March 2, 2011, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Estelle Montgomery, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Marcia Miller
Glen Yancey
Dr. Kevin Sundbye
Linda LeMieux
Kittie Umschild
Christy Caldwell, Topeka Chamber
Mary Jamiez
Tom Myers

Others attending:
See attached list.

The Chair opened the hearing on the proposed closure of the Kansas Neurological Institute (KNI). The Chair noted that proponents originally scheduled to appear canceled their appearance prior to the meeting but called the committee's attention to written testimony from Ray Dalton, Deputy Secretary, Disability and Behavioral Health Services, SRS (Attachment #1), Jane Rhys, Kansas Council on Developmental Disabilities (Attachment #2), and Brad Linnenkamp (Attachment #3). Senator Kelsey wanted his objection noted that there was no representation by government officials and requested that a member from SRS appear to respond to committee concerns.

The Chair welcomed Marcia Miller. Marcia is the advocate for her sister, a resident at KNI and gave the committee a rundown of her daily routine that would not be possible without the resources available to her at KNI (Attachment #4).

Glen Yancey expressed his concern over the pending closure of KNI. Mr. Yancey, a former disability examiner with the State of Kansas Disability Determination Services, stated that individuals who resided at KNI were far more profoundly affected by multiple developmental disabilities and ongoing medical problems than were those from other institutions. He feels that facility-based services such as those offered by KNI should be one of the options from which individuals with profound developmental disabilities and their families and caregivers can choose ((Attachment #5).

Senator Reitz said no Kansas legislator should vote on the proposed closure without visiting the KNI campus and meeting residents.

Dr. Kevin Sundbye, medical director for KNI and a Stormont-Vail Health Care physician, stated that he would do anything he could at anytime to see that this facility remain open. There are 168 residents at KNI and that it would ludicrous to attempt to relocate 75% of the population; the other 25% whom they have attempted to provide alternative housing have eventually returned to KNI. He reminded the committee that in addition to the more visible care provided there are also specialized provisions for the residents including dental care, a rail system for transporting residents, x-rays, lab work, IVs and a specialist for wheelchair alignment and adjustment to modify for pressure points for each individual resident. He feels that if these patients are outsourced they will do well for the first few months and then something will happen where the outsourced facilities will not be able to treat the patient, the staff at area hospitals will be overburdened, and finally the care facilities would not want them returned. He personally volunteered to take anyone interested for a tour of KNI.

The minutes of the Public Health and Welfare Committee at 1:30 a.m. on March 2, 2011, in Room 546-S of the Capitol.

Linda LeMieux is the sister and legal guardian for her brother. It discourages her that once again she is having to justify why residents at KNI deserve to remain in their home. The health of these residents has deteriorated and they have become even more fragile; therefore, their level of care and continuity of their home life need to remain constant now more than ever (Attachment #6).

Representing her brother Randy, Kittie Umscheid stated that closing KNI would result in the loss of expertise and experience of the current employees along with their understanding of the needs of those in their care. She was informed that Medicaid would not cover psychological treatment in the community so the developmentally disabled adults needing this type of treatment would go without due to a complex set of regulations (Attachment #7).

Representing the Greater Topeka Chamber of Commerce, Christy Caldwell stated that if the motive for closing KNI is saving the state dollars, that it receive careful consideration of whether there are real cost savings or cost shifts. The Chamber commissioned an economic impact analysis of KNI on Topeka for the State Closure Commission in 2009 (Attachment #8).

Mary Jamiez said it would be a terrible setback if KNI was destroyed because the state had a budget issue. She pleaded with the legislature to find ways to change, cut, consolidate and find the means to make it work so that the lives of their loved ones would not be disrupted (Attachment #9).

Tom Myers has a nephew at KNI and stated that the intense services available there just do not exist anywhere else. There may indeed be a savings by closing KNI but it would come at the expense of the residents and eventually their death.

Whitney Damron, appearing on behalf of the City of Topeka, respectfully urged care, compassion and caution by the Committee and the Legislature before moving forward to close a facility that has been providing critical services to the most vulnerable citizens of our community for nearly 50 years (Attachment #10).

Other written testimony in opposition to the closure of KNI was presented by Frances Sapp on behalf of her son (Attachment #11), Judy Ford on behalf of her son (Attachment #12), Ann Perrin Riggs (Attachment #13), and Robert Erickson, President and CEO at St. Francis Health Center and Maynard Oliverius, President and CEO of Stormont-Vail healthCare, Inc., asking for reconsideration of the decision to close KNI (Attachment #14), Jane Carter, Kansas Organization of State Employees (Attachment #15), and Arlene Leuszler (Attachment #16).

The Chair called the committee's attention to a packet of Petitions to Save KNI (Attachment #17).

Senator Kelsey moved that the committee unanimously support continuation of the great work of the Kansas Neurological Institute, seconded by Senator Brungardt. Senator Pilcher-Cook introduced a sub-motion to request in writing the appearance of the Secretary of Social and Rehabilitation Services before the committee to answer concerns, seconded by Senator Steineger. Both the sub-motion and the motion passed.

The next meeting is scheduled for March 3, 2011.

The meeting was adjourned at 2:30 p.m.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: Wednesday, March 2, 2011

NAME	REPRESENTING
ROBIN GRENIER	WASHBURN UNIVERSITY
Lacey Russell	Washburn University
Ashley Lang	Washburn University
Rae Jefferson	Washburn University
Rosilind Kort	Washburn University
Marci Watkins	KU
Misty Flewelling	Washburn University
Paige Webb	University of Kansas
Haleigh Riemer	University of Kansas
Perrys Malzahn	University of Kansas
Wendy Yung	University of Kansas
Beth Easterberg	University of Kansas
Elizabeth Kennedy	Washburn University
Kristy Pasnic	Washburn University/S.T.E.P.S.
Keri Ahlf	Washburn University
Shawn Moore	Washburn University
Brittany Owens	Washburn University
January Crawford	Washburn University
Angela O'Brien	Washburn

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: 3/2/2011

NAME	REPRESENTING
Amanda Herbey	KU
Dayna Langdon	KU
Marina Olsen	KU
Alaina O'Brate	KU
Glen Yancey	
Jimmy Pratt	
Kathy Olezak	
Barbara Coleman	
Bonnie Holman	
Alyssa Harvey	KU
Tori Komsthoeft	KU
Andrew Crandall	WU
Timothy Hawkins	WU
[illegible]	KCDD
[illegible]	KCSL
[illegible]	Topeka
Tobias Schlingensiepen	Coalition of Concerned Clergy
Marcia E. Bedyand	
[illegible]	TARC

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: 3/2/2011

NAME	REPRESENTING
Kevin Sundbye MD	KNI, Stormont Vail
Paul Schumacher	Washburn U.
Chad Austin	KHA
Roy L. Abbott	
Dale E. Cushinberry	Retired Citizen
Arlene Leuszler	KNI
Cassandra Byfield	KU - BSW
Marla DePriest	KU - BSW
Ashley Schultz	WU - BSW
Tania Sostre	Washburn University BSW
Megan Grechter	KSU - KSHA
Darcel Gronewoller	KSU - KSHA
Jamie Reinecke	KSU - KSHA

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: 3/2/2011

NAME	REPRESENTING
Samantha Atkisson	Washburn University
Rita Kaw	Washburn University
Samantha Burke	Washburn University
Shannon Stander	Washburn Univ.
Gerald Peterson	KNI
Carolyn Haller	University of Kansas
Amanda Nipps	University of Kansas
Tom Myers	KNI resident Sam King.
Frances Sapp	KNI Resident and son Sammy King
Norman Heyder	KNI Resident Russell Waltman
Linda Le Mieux	KNI Resident Russell Waltman
Mary Ann Jaime	Mom of KNI Resident Allen D Jaime
Christy A Caldwell	Topeka Chamber
Edward Larson	KS Cathdic Conference
Mindy Brissey	AFT - Kansas
Lisa Ochs	AFT-Kansas / KOSE
Deborah Myers	Washburn Univ.
Whitney Damron	City of Topeka

Rob Siedlecki, Acting Secretary

Senate Public Health and Welfare Committee

March 2, 2011

The Proposed Closing of Kansas Neurological Institute

Disability & Behavioral Health Services

Ray Dalton, Deputy Secretary

For Additional Information Contact:
Gary Haulmark, Director of Legislative Affairs
Docking State Office Building, 6th Floor North
(785) 296-3271

Senate Public Health and Welfare
Date 3-2-2011
Attachment 1

Senate Public Health and Welfare Committee

March 2, 2011

The Proposed Closing of Kansas Neurological Institute

Chairwoman Schmidt and members of the Committee, thank you for the opportunity to appear before you today to present information about the proposed closure of Kansas Neurological Institute (KNI).

As you are probably aware, the Kansas Facilities Closure and Realignment Commission's November 2009 report recommended that KNI be closed. It further recommended that SRS develop community placement criteria for people receiving services at KNI and Parsons State Hospital (PSH), and require those meeting the criteria to transfer to community based services; and that remaining individuals be served at Parsons State Hospital.

As a result, former Governor Parkinson issued Executive Order 10-01 to address the findings of the Closure and Realignment Commission as they relate to Parsons State Hospital and KNI closure and did not accept the commission's recommendations for KNI and Parsons State Hospital. SRS formed an advisory committee, made up of community providers and parents and guardians of people served by KNI and Parsons State Hospital, to develop a plan for the downsizing and possible consolidation of the two facilities.

Governor Sam Brownback through his budget supports the Commission's recommendations in regards to the closure of KNI.

We strongly believe that persons with disabilities should not spend their lives institutionalized and cut off from the community. Everyone deserves to improve their lives, and particularly those who are most vulnerable in society.

We understand that any change or transition is always difficult. And the concerns expressed by families, caregivers, advocates and the residents themselves are legitimate and we are taking them very seriously.

We are committed to a gradual transition, in which every person that currently resides at KNI will be treated with the utmost respect, sensitivity and care.

And we expect nothing less than excellence on the part of community service providers that will welcome those residing at KNI into group homes and other appropriate arrangements in the community.

Let me make this clear, this is not just a cost reduction issue. We want to improve outcomes and care for persons with developmental disabilities that will be transferring to the community. We want persons with disabilities to thrive and we will hold community providers accountable to this goal.

We believe that persons with disabilities have the right to live in the community, just like everyone else, as has been stated in U.S. Supreme Court decisions, the Americans with Disabilities Act, Federal guidelines, international conventions on disabilities, and particularly in the work of advocates, families, and persons with disabilities themselves.

With the direction from the Governor's Budget to begin the closure of KNI over a period of 23 months starting in FY2012, the advisory committee that was used to address Governor Parkinson's Executive order for the downsizing of KNI can be used to develop plans for the closure of KNI. In particular the advisory committee can be used to:

- Develop robust parent/guardian education and information strategies to help ensure they understand the community services available to support the success of community placements.

- Ensure SRS, the state hospitals, CDDOs and community service providers work with parents/guardians to ensure individualized person-centered support planning is in place to fully identify and meet the needs of each person transferring to community services.

- Ensure CDDOs and SRS work together to ensure appropriate community capacity needs are addressed.

- Ensure existing comprehensive quality monitoring systems will be utilized for the ongoing monitoring of services and outcomes for each person who moves to the community.

Response to Concerns that Have Been Expressed about the Closure of KNI

Does capacity exist in community service programs to meet the needs of that many people?

There are currently 8,006 Kansans receiving HCBS/MRDD waiver services. Of those people, 2,134 (27%) have a Tier 1 rating (indicating the most intensive service need). During the first six months of FY11, over 240 people were moved off of the MRDD services waiting list and into community services, and 33 of them have a Tier 1 service rating.

Does the community have the capability to provide the appropriate support to people with severe disabilities like those living at KNI?

When Winfield State Hospital was closed in 1998, 135 people with a Tier 1 service rating moved to community based services and have thrived there. The 74 people with Tier 1 service rating currently at KNI present the same type of support needs as many of those who made the successful transition from Winfield.

Will it be more dangerous for the people living at KNI to move to community services, and will it result in more deaths?

Our experience with the closure of Winfield State Hospital did not show this to be the result. Kansas has carefully, thoughtfully and successfully accomplished similar hospital closures in the past and in preparing for this closure we will include measures to ensure that service quality is objectively assessed and that safety nets are available.

What are the projected cost savings associated with the closure of KNI?

Based on information provided to the Closure and Realignment Commission, and on FY2009 data, the estimated annual savings, after all people have transitioned to community services (including that 75% of the people will have Super Tier increased funding rate and that there will be additional medical costs) are:

$14,398,523 (AF)
$6,054,578 (SGF)

What are the average costs for services for someone living at KNI vis-à-vis someone served in the community with HCBS/MRDD waiver-funded services?

The comparative costs based upon FY10 expenditures are:
KNI annual average cost per person: $180,471
Based upon level of support needed, we estimate this annual average cost for KNI residents moving to HCBS waiver services to be: $86,646

Is it fair to the people on the waiting list getting zero support to continue this level of spending at KNI.

Will the medical costs be more in the community?

There will be an increase in Medicaid-funded physical health costs when KNI residents move to the community, and this has been factored into the projected savings. Our experience from the closure of Winfield State Hospital, and our experience with people receiving MRDD waiver services do not indicate that there will be an extraordinarily large increase in the medical costs.

What is the effect of this closure on the MRDD waiver waiting list?

No direct effect. The people at KNI are currently receiving a Medicaid-funded service, and are entitled to receive such service adequate to meet their needs. By closing KNI and transferring each person to HCBS/ MRDD waiver-funded services, they would be shifting the type and location of their services and would be transferring the funds necessary to access those services.

We feel confident, Chairwoman Schmidt, that we can achieve the necessary projected savings while improving outcomes for all those involved in this transition.

This concludes my testimony and I will be glad to answer any questions you might have.

Kansas Council on Developmental Disabilities

SAM BROWNBACK, Governor
KRISTIN FAIRBANK, Chairperson
JANE RHYS, Ph. D., Executive Director
jrhys@kcdd.org

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"To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities"

SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

March 2, 2011

Madame Chairwoman, Members of the Committee, thank you for the opportunity of providing written testimony regarding the closure of Kansas Neurological Institute (KNI). The Kansas Council on Developmental Disabilities is a federally mandated and funded entity under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000. Our role is to study and examine the Kansas system for people who have Developmental Disabilities and to advocate with policymakers for improvements.

This is an item of great concern to the Council. The Council was an active participant in the closure of Winfield State Hospital in the mid 1990's. At that time we had KNI, Parsons State Hospital (PSH) and Winfield State Hospital. Winfield was known as the state DD hospital that had the most medically fragile residents, the ones who needed the most individualized care. Yet, in the mid 1990s, Kansas successfully closed Winfield with the majority of its residents moving to the community. How did these very medically fragile individuals do in the community?

In collaboration with the Legislative Coordinating Committee, the Council jointly funded a study of that closure and the outcomes for the Winfield residents who moved to the community. The results of that study and a recent (fall, 2010) update of the study, proved that persons with developmental disabilities have more inclusive lives and better health when they do not live in a large, congregate facility. The attachment is the updated report on how former Winfield residents are faring.

There are over 8,000 individuals with developmental disabilities living in the community today. Some of them are those medically fragile persons who used to reside at Winfield. Others are

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ersons who formerly lived at one of the other institutions or whose parents and relatives have provided for them, with the assistance of the state, in the community. They are young, old, African American, Asian, Hispanic, male, female; in short, they resemble the population of Kansas because disability knows no boundaries. Some have moderate to mild forms of cognitive and/or physical disabilities. Others are more severe and have needs similar to those still at KNI or PSH. All receive some services and all are benefitting from the Medicaid services, including medical services, for which the state and federal government each pay a share.

The Governor has recommended closure of KNI and we applaud his recommendation. We concur with one change – we believe that any and all savings from the closure of KNI must be used to improve the Kansas DD system. It is impossible to predict exactly what such savings will be, given that we do not know exactly what the costs of moving to the community will be. We do have a federal grant, Money Follows the Person, that can assist with some costs and we also know that Medicaid will assist in paying for community medical costs.

We urge you to carefully examine hospital closure and begin the process of closing KNI with the proviso that any and all savings be used to assist people who are on the waiting list and who serve these individuals in the community.

As always, we thank you for permitting us to testify and would be happy to answer any questions you may have. Please feel free to contact me – my information is below.

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Are People Better Off?
Outcomes of the Closure of Winfield State Hospital
13 Years Later

A Follow Up to the Final Report (Number 6) of the Hospital Closure Project
Issued by Dr. James Conroy in December, 1998

Submitted to:
The Kansas Council on Developmental Disabilities

Submitted by:
Della Moore
Director of Quality Assurance
Creative Community Living, Inc.
1500 E 8th Avenue
Suite 208
Winfield, KS 67156
620-221-9431, FAX 620-221-9336, email della@cclccl.org

October, 2010

In December of 1998 Dr. James Conroy submitted his final report on the closure of Winfield State Hospital. He referred to the people moving from the hospital as Movers. His report was extensive using a multitude of measures. At that time he stated, "Movers are believed to be better off." (Conroy, p.33)

The logical question is how well Movers are doing today, 13 years later. While we have neither the time nor the resources to replicate Dr. Conroy's work, we believe the 14 quality of life dimensions used by Dr. Conroy offer a strong basis for comparison (Conroy, p. 33). We further believe the parents/guardians of the Movers offer the most reliable information as the Movers do not communicate verbally well or at all. With that in mind we were able to contact 40 parents/guardians of the Movers from 1997. We contacted the parents/guardians via telephone and used the following script to administer the survey.

Script for phone interview:

My name is _____ and I work for Creative Community Living. We are collecting information to share in summary form with the Kansas Council on Developmental Disabilities. This information will most likely be used in testimony before legislators as they examine closure of another state hospital. This short survey should only take 5 – 10 minutes of your time. May I proceed? (If answer is "no", ask if there is a more convenient time you can call. If the answer is still "no", thank them and hang up.)

Every parent/guardian we were able to reach participated in the survey.

We anticipated there would be a slight increase in the level of satisfaction with community-based services. We did not anticipate the degree of increase in all dimensions.

Category	State Hospital	Year 1	Year 13
Health	2.6	2.7	4.3
Running his/her own life - making choices	2.2	3.0	4.0
Family Relationships	2.1	2.3	3.9
Seeing friends, socializing	2.3	2.8	4.2
Getting out and getting around	2.3	3.1	4.3
What he/she does all day	2.5	3.1	4.1
Food	2.6	3.5	4.2
Happiness	2.8	3.3	4.3
Comfort	2.9	3.4	4.5
Safety	3.1	3.5	4.3
Treatment by staff	3.4	3.8	4.4
Dental care	2.9	2.4	4.2
Privacy	3.2	3.7	4.3
Overall quality of life	3.0	3.5	4.4

The comments offered by many parents/guardians also supported the increase in degree of satisfaction. Below is a sampling of the positive comments:

- Can tell you in every aspect of their lives things are much better now than at State Hospital.
- As far as her life now is concerned, I really couldn't ask for it to be better.
- I think families are much more comfortable visiting in the community than they were at State Hospital. I've seen a lot of change in my life and that was one of the most positive.
- Life improved dramatically as has health.
- At first I was opposed to closure of State Hospital but I feel she would not have had the opportunities she does now.
- I feel he gets much better care now and has better Quality of Life than when at State Hospital.
- Safety is much better now, more one-to-one care.
- There wasn't as much preventative medical treatment, more reactive. I was one of the last to think this was possible.
- Think whole transition has gone well – better for everyone.

Obviously, there was some dissent although very minimal. Approximately 99% related to staff turnover, but there was consistent praise of the job done by staff today. As one parent phrased it, "There is always someone who cares."

Family relationships showed the least level of increase. The comments relating to those scores referred to declining health and death of family members rather than discontent with community settings. As the comment section shows, many family members found it more convenient and/or comfortable to visit in the community.

Dr. Conroy wrote in 1998, "The Kansas experience of the closure of Winfield has been far more successful than this consulting team predicted." (Conroy, Executive Summary) Thirteen years after the closure the success seems to have kept building.

March 1, 2011

Brad Linnenkamp

Self Advocate Coalition of Kansas

To: Senate Committee on Health and Welfare

I am writing in support of the closing of Kansas Neurological Institute.

As an advocate and a person with a disability The Self Advocate Coalition of Kansas believe people regardless of their disability should be able to live and work in the communities they choose.

People that can get the supports and services in the communities where they live, can feel a more a part of the community and live a more fulfilled life.

Living in the community cost less and the money saved could go toward the waiting list to help other get the supports and services they need.

Living in the community is the right thing.

Sincerely

Brad Linnenkamp

Self Advocate Coalition of Kansas

Senate Public Health and Welfare
Date 3-2-2011
Attachment 3

KNI is Nancy's home. Nancy is my sister. She shares her home with other residents who have profound developmental disabilities, medically fragile like she is. Their home is quite modest; a kitchen where there is a table big enough for them to all gather around for meals, a family room where there are a few recliners along with a sofa to relax when it is time for some television watching or picking out a favorite DVD. And, when a nap is in order or it is time to say good night they head to there bedrooms where each has a bed, like my bed or maybe your bed. There is room for them to move around in their wheelchairs from one area of their family room, where a couple of tables are set up with puzzles or board games, to where the television is. There are, of course, many other things that help make KNI home. Nancy knows when she wakes up in the morning Christine will be there to get her up, bath her, take the time to plan what clothes she will wear and perfectly groom her hair maybe a ponytail or a braid and always includes pretty hair clips or a colorful daiy. The other residents also enjoy this same personal attention. These are the things that you and I enjoy in our homes, a place where there are familiar faces, voices, knowing that this is where the things we need are. It is warm and safe here. This is where my SECURITY is. KNI provides this all important element for those we love, SECURITY.

Testimony presented to the
Senate Standing Committee on Public Health and Welfare

By Glen Yancey
March 2, 2011

Dear Chairperson Schmidt and Honorable Subcommittee Members:

Thank you for the opportunity to present my concern over the pending closure of the Kansas Neurological Institute in Topeka. I feel very strongly that it would be a grievous mistake to close the facility and want to voice my individual support for keeping it open. Moreover, I believe that my professional background qualifies me to speak to the issue credibly.

My name is Glen Yancey. I was employed as a disability examiner with the State of Kansas Disability Determination Services for nearly 8 years, and then served as director of the program for another 25 years. Following that, I served another 4 1/2 years as Commissioner of Rehabilitation Services before retiring from State service. While Commissioner, I was a member of the Kansas Planning Council on Developmental Disabilities, the Kansas Commission on Disability Concerns, the Kansas Commission for the Deaf and Hard of Hearing, the Statewide Independent Living Council, the Governor's Mental Health Planning Council, and the Governor's Task Force on Adult Literacy and Learning Disabilities. Most recently, I served for four years as executive director of Breakthrough House, Inc. of Topeka, a nonprofit organization providing community-based support services for persons with mental illness. I am currently president of the Kansas Mental Health Coalition, and I am a retired local pastor in the United Methodist Church, having served churches in Pomona, Vassar, and Ozawkie.

During my tenure with the State, I became well acquainted with the patient populations at all of the State institutions, both for persons with mental illness and for those with developmental disabilities. While working as a disability examiner, I personally adjudicated hundreds of individual claims for Social Security and SSI disability benefits. I observed that as a group, the individuals who resided at KNI were far more profoundly affected by multiple developmental disabilities and ongoing medical problems than were those from other institutions. Moreover, KNI's population included a greater percentage of individuals with the most severe impairments. While some have pointed to the closure of Winfield State Hospital as an example of a successful transition from institutional care to community-based care that can serve as a model for KNI closure, based on my experience of the differences in the makeup of the populations at the two institutions, this is not a valid comparison. Furthermore, as I recall, residents at Winfield who were determined unable to live in a community setting because of the severity of their disabilities were transferred to other institutions—namely KNI and Norton—rather than being placed in community settings.

I have long been an advocate for independent living for persons with disabilities. In fact, while serving as Commissioner of Rehabilitation Services, I was successful

in securing funding for three new independent living centers. I am also a strong believer in, and advocate for, community-based services. Nonetheless, and with all due respect to some of my well-intentioned colleagues, I don't believe in a one-size-fits-all approach--i.e., I don't believe community-based services are the answer to every individual's needs. To me, facility-based services such as those offered by KNI should be one of the options from which individuals with profound developmental disabilities and their families and caregivers can choose. And in fact, for some individuals with such profound disabilities, facility-based services may not only be the best option, such services may be the only option that will satisfactorily meet their needs.

Ladies and gentlemen, I urge you to keep KNI open. Please save this important and unique resource for people with profound developmental disabilities, because once it is gone, it will be gone forever.

Respectfully submitted,

Glen Yancey

Glen Yancey
3311 SW Jardine Ct.
Topeka, KS 66611-1850
Phone: 266-6670

March 2, 2011

TO: Senate Public Health and Welfare Committee

RE: Kansas Neurological Institute

My name is Linda LeMieux, sister and legal guardian for my brother, Rusty Waltman. I'm here today to advocate not only for Rusty, but for all residents at KNI. I am encouraged that there are those of you who agree with keeping KNI open. However, it is very discouraging to once again be here before a committee justifying why residents at KNI deserve to remain in their home. Nothing has changed since the last decision to keep KNI open in September 2009... if nothing else, the health of these residents has deteriorated. They have become even more fragile and their level of care and continuity of their home life needs to remain constant now more than ever.

My brother, Rusty, is 54 years old and has lived at KNI since he was 6 years old (that's 48 years). Rusty is profoundly mentally and severely physically disabled. Due to his severe neurological disorders, he cannot swallow, thus requiring a feeding tube. He cannot talk so his only mode of communication is making sounds. He also takes many medications (including medications that control grand mal seizures) which require continual monitoring. He cannot walk. He is bound to his wheelchair. Rusty, as well as all of these residents, truly needs the expert care that KNI provides 24/7.

Not only that but... the Honeybee staff/caregivers at KNI where Rusty lives are his family (his mothers, fathers, brothers, sisters, grandmothers, friends, etc.). If KNI closes, it would be like ripping him away from them. He would not understand and would be very confused. He would continually cry out and yell because this is the only family he knows. All others are strangers. Please keep in mind that many of these Honeybee residents have been together for many, many years. Continuity of care and continuity of family for these residents is crucial. The residents would never be part of a family within the community as there is no continuity of care. Turnover at KNI is only 15% compared to 51% elsewhere. Their lives would be in constant turmoil and flux, and their lives would be put in grave danger. Due to their longevity, the staff/caregivers at KNI know exactly what he needs, when he needs it.

Many of the KNI residents, Rusty included, are not suited to be placed in a group home setting or community living. Also, a transfer to Parsons would not be appropriate where the nearest medical facility is in Joplin, MO, across state lines. Most residents would most likely not even survive the ambulance ride. KNI has its own medical unit, and in the case of more severe medical conditions, Stormont-Vail Hospital is very close. Many KNI parents and guardians have investigated and visited many facilities and found there are no

alternatives that offer the same level of care and expertise that the KNI facility and staff provides to our loved ones. I believe that some of you have also come to that same conclusion. If what the SRS communications representative promised during a discussion on KPR a few weeks ago that all KNI residents would only be transferred to facilities that are as good or better than KNI... then the residents at KNI should truly have nothing to worry about as there are no other facilities that currently exist that are as good or better than KNI.

Another important item to bring forth is that KNI also serves the greater community... outside of KNI. KNI is very progressive and has the expertise and equipment to ensure all wheelchair-bound residents of KNI and non-residents (who seek their service) have proper wheelchair specifications in regard to body support, angles, etc. Wheelchair assessments are based on each unique individual assuring his/her physical wellness. KNI also has a dental program and an eye program that also serves the greater community of those with disabilities. So not only would you be taking these services away from KNI residents, but for the greater community at large.

On my brother's behalf and on behalf of the other residents at KNI, we plead with all of you to be humane and make the responsible decision to recommend that KNI remains open, not only because of their fragile medical needs and their unique circumstances, but because KNI is their family. They all deserve to be supported and cared for by the best, and KNI is the best. On a personal level, this is the only home that Rusty has ever known. To move him now would be a real detriment to his personal well-being as well as pose a real health risk to this fragile man. I truly believe Rusty will die should he be yanked from his home at KNI.

Please... these residents deserve to remain in their homes with their family.

With kind and warm regards,

Linda LeMieux

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Kansas Senate Health and Welfare Committee
March 2, 2011 1:30, 546-S Capitol Bldg.

Kittie Umscheid, 17956 157th Street
Bonner Springs KS
913-724-2710

My name is Kittie Umscheid. I am co-guardian for my brother, Randy Bayer, who lives at K.N.I. Thank you for allowing this time to express my concerns. Randy moved to KNI when Winfield closed – literally about 6 weeks prior to actual closure. There was no community facility which would take him. About 24 others also chose KNI.

With the issues of Health and Welfare in mind, I will briefly list some details as I know them. The Olmstead Decision and CDDO's imply that moving our loved ones into the community will improve their "quality of life" and that "choice" is a priority.

Randy's quality of life will not be improved if moved into the community.

1. Annually SRS requires a Report To The Court regarding the criteria for residing at KNI. Randy's most recent Court report determines that placement at **KNI is the "least restrictive" alternative available to him.**

2. Upon arrival at KNI, Randy had aggressive behaviors which took several years to understand and reduce. With a complete change in his environment, this aggressive activity will certainly return and those living with him or caring for him will suffer. KNI's psychology dept. tells me that Medicaid does not cover psychological treatment in the community. If KNI closes, Jeanne Tomiser, head psychologist there, will not be able to serve Developmentally Disabled (DD) adults due to a complex set of regulations. Trying to find a licensed psychiatrist in Topeka was impossible due to low Medicaid rates and the doctors being unfamiliar with the DD population. Therefore, Randy's trips to see a psychiatrist to manage his psychotropic medications must be to Kansas City which requires 2 staff members at least a half day trip; a lot of sitting time.
Not an improvement in quality of life.

3. When Randy spent a week in the hospital last fall, KNI had a staff person with him at ALL times. This coverage is critical for a patient with developmental disabilities who has no comprehension of what is happening. In community facilities, there will be only minimal coverage with no one there during the night. With each health issue, whether serious or minor, there will be increased hospital visits since rarely is medical help available on site. On-call nursing does not replace the daily rounds of an RN to monitor his problems or the Medical Unit at KNI. And 6 month dental checkups at KNI are unlikely in the community.
Not an improvement in quality of life.

4. Moving to Parsons SH&TC is not an answer; every connection with Randy would suffer. The distance alone causes a hardship for all his family and he deserves better.
Not an improvement in quality of life.

5. The thought of loosing over 500 employees at KNI is an important financial issue, but I realized we would **loose their expertise**. Regardless of the level of pay or position the KNI employees have, their experience, their understanding and their commitment in caring for the DD population is immeasurable. For the many residents who cannot speak, close observation is critical, something that takes time to learn. The 51% staff turnover rate in community facilities would weaken this fragile balance.
Not an improvement in quality of life.

6. I have included a printout of an article written in the "*Mental Retardation*" publication. The first sheet dated 2009 reconfirms the details of an earlier study. The conclusion states "***it is clear that large savings are not possible within the field of developmental disabilities by shifting from institutional to community placements".*** Please read the summary and if anyone would like the full research study, I'd be most happy to order one.

An excellent recommendation was passed last week by the Ways and Means Committee. Let the independent audit find ways to help KNI and Parsons economize and continue the significant work of caring for special needs residents.

In grateful appreciation to the tax payers of Kansas for the blessing of Randy's home at KNI, we thank you.

Kittie Umscheid

Kittie Umscheid

Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research

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Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research

Kevin K. Walsh, Theodore A. Kastner, and Regina Gentlesk Green

Abstract

A review of the literature on cost comparisons between community settings and institutions for persons with mental retardation and developmental disabilities was conducted. We selected literature for review that was published in peer-reviewed journals and had either been cited in the area of cost comparisons or provided a novel approach to the area. Methodological problems were identified in most studies reviewed, although recent research employing multivariate methods promises to bring clarity to this research area. Findings do not support the unqualified position that community settings are less expensive than are institutions and suggest that staffing issues play a major role in any cost differences that are identified. Implications are discussed in light of the findings.

The significant growth of community-based services has given rise to a dramatic shift in how services, especially residential services, are provided to people with mental retardation. As community-based services have expanded relative to institutions, aspects of costs, efficiency, and outcomes have grown in importance to practitioners, policy makers, and researchers (Braddock, Hemp, & Howes, 1986, 1987; Braddock, Hemp, & Fujiura, 1987; Campbell & Heal, 1995; Felce, 1994; Harrington & Swan, 1990; Mitchell, Braddock, & Hemp, 1990; Murphy & Datel, 1976; Nerney & Conley, 1992; Rhoades & Altman, 2001; Stancliffe & Lakin, 1998). Despite the reduction in the number and size of large facilities that accompanied the increase in community-based residential services, large facilities are still with us. Tracking of facility trends shows that there are still more than 250 facilities nationwide with 16 or more beds serving nearly 48,000 individuals, 80% of whom are classified as having either severe or profound mental retardation (Prouty, Smith, & Lakin, 2001; Lakin, Prouty, Polister, & Kwak, 2001; Smith, Polister, Prouty, Bruininks, & Lakin, 2001). According to Polister, Smith, Prouty, and Lakin (2001), of the state-run facilities with 16 or more beds, 113 of them (nearly 60%) serve 150 or more individuals.

Several factors underlie the continued use of large facilities, including the institutional bias produced by the entitlements in federal Medicaid programs along with the pace of community expansion and the characteristics of the individuals themselves. For example, although community residential settings with 15 or fewer residents now number nearly 120,000 nationwide, waiting lists continue to grow and are a concern for policy makers and service providers. In studies of waiting lists, Davis, Abeson, and Lloyd (1997) and Lakin (1996) found between 52,000 and 87,000 individuals waiting for residential services, and nearly 65,000 were waiting for day programs. Overall, Davis et al. reported that 218,186 people were waiting for *any* type of services. Emerson (1999) has identified the same problem in the United Kingdom. Thus, the demand for community services for people with mental retardation and related developmental disabilities (MR/DD) has grown faster than the capacity of states to expand or create new community-based services.

The characteristics of individuals remaining in institutional facilities has also changed. Individuals still in institutions tend to be older and have more problems in daily living skills and in walking independently (Prouty et al., 2001). Although challenging behaviors are observed in both institutional

and community settings, more individuals remaining in large settings present challenging behaviors (Borthwick-Duffy, 1994; Bruininks, Olson, Larson, & Lakin, 1994). On average, about 47% of residents of large state facilities are reported to have behavior disorders, a statistic that has slowly increased since the late 1980s, from around 40%.

Although many have argued that institutions cost more than community settings (e.g., Heal, 1987), others have reported minimal cost differences (e.g., Schalock & Fredericks, 1990) or differences that favor institutions (e.g., Emerson et al., 2000). These different outcomes arise from the inherent complexities of research in this area, which is characterized by a heterogeneous population, complex funding strategies, methodological challenges, and substantial variability (cf. Butterfield, 1987).

Because a diversity of viewpoints exists, and because both settings are likely to coexist for some time, it is reasonable to review research in which investigators have examined the costs of these service models. This research area is rich in complexity and, although policy reports on costs and expenditures have appeared (e.g., Braddock, Fujiura, Hemp, Mitchell, & Bachelder, 1991; Braddock, Hemp, & Fujiura, 1987; Harrington & Swan, 1990; LeBlanc, Tonner, & Harrington, 2000), few reviewers of the cost literature have critically examined methodological elements of the available cost-comparison studies. This has added to the difficulty in drawing firm conclusions.

Although recent literature in this area has, to some extent, included evaluation of outcomes in addition to service costs, our primary focus in this article is on research in which costs were compared. This is not to denigrate the importance of outcomes; rather, our focus reflects the limitations of a single paper as well as the reality that although government officials and service elements typically desire to take quality and outcomes into account when planning programs, legislators often respond more directly to cost issues in funding decisions.

Considerations in Comparing Costs

Sources of Funds

Although services and supports for people with MR/DD are administered by states, the funds to pay for them are not limited to state funds; funds also come from local (e.g., county) and federal sources. The federal government plays a substantial role in states through the Medicaid Intermediate Care Facilities for the Mentally Retarded (ICF/MR) program and the Home and Community-Based Services (HCBS) Waiver program (Harrington & Swan, 1990; LeBlanc et al., 2000; Miller, Ramsland, & Harrington, 1999). Services for people with MR/DD in states are funded, to a large extent, through these two programs, which provide matching funds, with the proportions of federal and state contributions varying across the states (Braddock & Fujiura, 1987; Braddock & Hemp 1997; Braddock, Hemp, & Fujiura, 1987; LeBlanc et al., 2000; Lutsky, Alecxih, Duffy, & Neill, 2000; Smith & Gettings, 1996). Currently, all 50 states have at least one active ICF/MR facility (Centers for Medicare & Medicaid Services, 2001), although not all ICF/MR facilities are large (i.e., institutions). Most large state-run facilities participate in the ICF/MR program, although there are large private ICFs/MR as well.

The HCBS Waiver program aids states in providing habilitative and other supports in community settings. Eiken and Burwell (2001) reported that

> about three-fourths of (federal) Waiver expenditures are used to purchase long term care supports for persons with mental retardation and other developmental disabilities. In FY 2000, about $9.3 billion of the total $12.4 billion spent for HCBS Waiver services was targeted to persons with MR/DD.

This amount nearly equaled the $9.9 billion spent on ICF/MR services in the same year. Since 1995, the average annual growth rate of HCBS Waiver services for people with MR/DD has been over 17%, whereas spending for the ICF/MR program has increased, on average, by less than 1%.

Cost Shifting

Results of early unpublished studies suggested that large facilities were up to 2.5 times as expensive as community facilities (e.g., Ashbaugh & Allard, 1983; Wieck & Bruininks, 1980). However, such conclusions are no longer valid because the analyses took place prior to the full operation of the HCBS Waiver program. Given the differences in the ICF/MR program and the HCBS Waiver program, there is the potential for costs to be *shifted* in complex ways. For example, whereas a placement in a large ICF/MR facility involves both state and federal funds, in varying proportions and at different levels across the states, not all community placements receive federal funds. Although some community-based placements are funded by both federal and state funds (e.g., under the HCBS Waiver), other services and supports are funded

solely by state funds, or are funded by complex combinations of personal/ private funds (including "entitlement" funds under Social Security) along with state funding.

In addition, the federal component of funding under both Medicaid programs varies from state to state, and for the HCBS Waiver, it varies based on what is contained in each state's Waiver agreement with the Centers for Medicare and Medicaid Services (CMS). Consequently, as fewer individuals are served in ICF/MR settings and more receive HCBS services, certain costs may be shifted to other Medicaid programs, or other state funds. According to Lutsky et al. (2001):

> Per recipient Waiver spending fails to capture actual spending on Waiver recipients because it only accounts for a portion of their expenditures. HCBS Waiver recipients typically have some of their care, most notably acute care, home health, personal care, targeted case management, and adult day care, funded from the regular Medicaid program. (p. 8)

Cost Variation

Costs vary both *between* and *within* agencies and service systems, based on complex factors that affect them in several ways. Very similar services may vary widely in costs based on geography (e.g., urban vs. rural), unionization of staff, availability of professional staff, staff levels and ratios, ownership status (i.e., public vs. private), and other local factors in addition to characteristics of the consumers served. Such cost variation has been a consistent finding in the literature (Campbell & Heal, 1995; Mitchell, et al., 1990; Nerney & Conley, 1992).

Service costs also change over time as dynamic service systems constantly alter their complexion. For example, costs per resident in an institutional facility tend to rise when the most capable residents are removed and placed in community-based facilities. In addition, cost variation is typical both within and between service facility types. For example, in a study comparing costs in the United Kingdom, Hatton, Emerson, Robertson, Henderson, and Cooper (1995) reported average per person cost variations of as much as $20,000 between institutional placements and specialized units *within* institutions and the same amount of variation among regular group homes. This phenomenon has also regularly appeared in the literature in America (e.g., Jones, Conroy, Feinstein, & Lemanowicz, 1984; Lakin, Polister, Prouty, & Smith, 2001; Nerney & Conley, 1992).

Staffing

Staffing levels and ratios have been identified as one of the major sources of cost differences across settings (Campbell & Heal, 1995; Felce, 1994). In addition to variability in staffing ratios across settings, there are clear-cut differences in salary and benefit levels. For example, public employees typically have richer compensation packages, and there may also be increased costs associated with the availability of professional and therapy staff. In short, staffing is not a stable variable with wide variability in compensation levels across settings and high rates of turnover (e.g., Braddock & Mitchell, 1992). Staffing levels and costs associated with staff, including recruitment and retention, vary depending on the needs and conditions, and the regulations in a particular setting (Larson, Hewitt, & Anderson, 1999). Therefore, costs associated with staff will prove to be a critical variable in all service models in the future.

Case Mix and Functioning Level

As community services expanded during the past quarter century, the average functioning level of individuals remaining in institutional facilities declined while, in general, their average age increased compared to the general population served by state agencies. These changes have taken place because fewer individuals overall were placed in institutional facilities, and special efforts were made to restrict the institutionalization of children (Lakin, Anderson, & Prouty, 1998). In addition, individuals with more skills and abilities are typically placed in community settings before individuals with more complex needs.

Thus, there are now stark differences in the populations served in community settings and those remaining in larger settings, typically public ICF/MR facilities. With respect to comparisons between these two groups, whether on costs, functional skills, quality of life issues, and so forth, population differences must be considered. In research terms, this process is known as *correcting for case mix* or *controlling for client mix* (Mitchell et al., 1990) and assures comparability based on characteristics of consumers. The importance of correcting for the severity of those served is underscored by Felce and his colleagues (Felce, Lowe, Beecham, & Hallam, 2000), who concluded that "costs of residential services in general have been found to depend on case mix, with the mediating variable being level of staff per resident" (p. 309). Taken together, the factors

of funding source, cost variation, staffing, and case mix are well-known and central to the cost-comparison literature. We now turn to a selective review of the literature showing how the research has addressed these and other issues in studies of service system costs in the MR/DD field.

Literature Selection

To show how the phenomena described above can affect conclusions about costs, we present a historical review of cost-comparison literature, highlighting studies that have gained prominence or address the issues raised herein. A comprehensive literature search was conducted using standard search strategies (Nerney, 2000) in several computerized databases (e.g., Medline, CINAHL, ClinPSYCH, PsychSCAN LD/MR) using keywords (e.g., *mental retardation*, *developmental disabilities*, *ICF/MR*, *costs*, *community*, *institution*) directly or in combinations to create Boolean searches. Two project members conducted literature searches using selection criteria requiring that identified documents (a) covered the MR/DD population; (b) included cost data or cost-related policy analysis; (c) were published or available since 1975; (d) were not case studies; and (e) were focused, at least in part, on residential services. Search results, including full identifying information, were saved electronically. Documents were then selected from these search results to form a document database. Documents that were selected were acquired, entered into the database, and stored in hard copy form. To assure that the two team members were selecting documents using the same criteria, we calculated average agreement at 88.5% on selections made from three large search result files. In addition, we regularly discussed search results and selections at project team meetings. Once acquired, the reference lists of documents were also searched for additional items not previously identified. Approximately 250 documents were identified and acquired in this way to form a working database.

Documents in this database were read and a smaller number selected for specific review if they (a) were published in peer-reviewed journals; (b) included community–institution cost comparisons; (c) were referenced in the cost-comparison literature; and/or (d) included a unique methodological element or approach, were frequently cited in the literature, or were illustrative of a specific historical point. Because of these stringent criteria, only a small sample of the documents are specifically reviewed herein.

Research Review

Peer-reviewed articles were selected for review in this section to provide a historical glimpse of the cost-comparison literature over the past quarter century. Studies were selected that have a bearing on policy issues in the field, especially those related to cost comparisons. A summary of some of the selected studies is provided in Table 1. Because absolute levels of costs are less important here than comparative costs, no attempt has been made to adjust costs to a common fiscal basis. Therefore, caution must be exercised because the studies span a broad time period. Although comparisons *within* studies are possible, costs may not be directly comparable, on a dollar basis, *between* studies because of inflation and other factors.

Murphy and Datel (1976)

In this early cost–benefit analysis, Murphy and Datel reported that a community-placement program in Virginia produced an average net savings, across 52 residents, of $20,800 per resident over 10 years (range = $13,000 to $29,000) or, on average, $2,080 per person per year. They noted that most of these savings accrued to the state rather than to the federal government. Murphy and Datel used complex data collected across system elements, and their often-cited 1976 study is not without methodological problems. One concern is that participants were not representative of the MR/DD population in two ways. First, over half of the 52 individuals studied (61.5%) did not even have mental retardation or other developmental disabilities, coming instead from a rural facility for persons with mental illness, thus also possibly underrepresenting urban and suburban settings. Second, participants were screened, and those who were not likely to succeed in community placement were excluded. Admittedly, Murphy and Datel's main purpose was to assign costs to benefits of community placement and was not a formal cost-comparison study per se. Despite this purpose, the study is often cited in the context of cost comparisons. Further, with regard to methodology, the authors noted that "90 percent of the data on costs and benefits over the ten-year period were based on *projections*" (p. 169, emphasis added). The basis of these projections was, on average, only 8.5 months of community living. Al-

Table 1 Characteristics of Reviewed Studies

Source	Settings and subjects	Cost outcomes	Factors limiting generalization
Murphy & Datel, 1976	*N* = 52; MH = 62% MR/DD = 38% (moderate, severe, or profound); Ss placed from 4 institutions in VA	Average net savings of $2,080 per year per client in community services. Subgroup showing no cost–benefit from community placement, most similar to current institutional population	Mixed, nonrandom, nonrepresentative (of MR/DD) sample. No correction for severity or case-mix Sample screened to eliminate potential community placement failures 90% of data derived from estimates (based on 8.5 months of community placement) No accounting for start-up or capital costs
Jones et al., 1984	*N* = 140; 70 "movers" and 70 matched "stayers"; 85% severe or profound; drawn from Pennhurst facility in PA	Overall cost difference between community placement and public institution reported as $6,886 per resident per year	Different cost-aggregation methods across groups; relied on self-report cost data from community providers, including estimates, compared to accounting records for institutions Rater differences across groups Exclusion of three high-cost community cases No accounting for start-up or capital costs
Schalock & Fredericks, 1990	Fairview facility (OR) with census of 1,084 compared to 4 group homes and an apartment program (combined capacity = 25)	Average annual per person ICF/MR costs = $59,412 compared to $53,635 in community settings; costs in two group homes most similar to Fairview population = $60,615; equalizing raw costs for staff levels, community settings were more expensive	Small *n*-size in community setting No control for case-mix factors (i.e., community setting individuals not fully comparable to Fairview population) Few client characteristics provided to allow case-mix correction Day program costs were only *estimates* from budgets Community medical costs estimated from individual appointment records/documentation rather than billing encounter data

(Table 1 continued)

Table 1 Continued

Source	Settings and subjects	Cost outcomes	Factors limiting generalization
Nerney & Conley, 1992	*N* = 375 living arrangements (group homes and nonfacility care) in 3 states (MI, NE, NH) compared with institutional costs	Institutional Care Rates (from records) Michigan: $63,000 Nebraska: $19,391 New Hampshire: $28,411 Community Rates (corrected using 50% split on need) Michigan (non-ICF): $47,359 Michigan (ICF): 48,487 Nebraska: $25,778 New Hampshire: $42,007	Data collected at facility level; incomplete correction for case-mix factors Different cost aggregation methods across settings Extreme variability in costs Education and Medicaid-reimbursed costs excluded No accounting for start-up or capital costs
Knobbe et al., 1995	*N* = 11; all severe/profound with challenging behaviors; placed from state facilities into homes serving 3 individuals	Overall cost savings in community of $6,154 per person per year	No accounting for start-up and capital costs Estimates for community medical service costs appear to be underestimates
Campbell & Heal, 1995	*N* =1,295 "observations" of clients living in all settings in South Dakota	Average annualized adjusted rates reported as: ICF/MR = $55,560 ICF/15 = $39,077 HCBS = 25,813 Community Training Services = $21,210 Costs found to be associated with client characteristics, agency characteristics, funding source, staff : client ratio, and certain geo-demographic variables	Possible case-mix problems given loss of 29% of community sample Artificially high cost prediction may be due to use of aggregate vs. individual cost data
Stancliffe & Lakin, 1998; Stancliffe & Hayden, 1998	116 individuals moved to community settings and 71 remaining in institutions in MN	Average per person annual costs: $115,168 in institutions; $84,475 in community settings	Medical and case management costs excluded from analyses Covariance methods may not have fully equalized groups

(Table 1 continued)

Table 1 Continued

Source	Settings and subjects	Cost outcomes	Factors limiting generalization
			Possible bias in at least one measure selected as a covariate Cost aggregation methods differed across settings No accounting for start-up or capital costs
Emerson et al., 2000	86 adults in village communities; 133 adults in new residential campuses; 281 adults living dispersed housing schemes (group homes and supported living)	Averaged annualized per person costs (converted from pounds sterling to 1997–1998 dollars): Residential campuses = $74,516 Village communities = $71,604 Dispersed housing in community = $85,852	Overall system of services in UK may not be directly comparable with United States Non-random sample with relatively few exemplars of each model of service

Note: Because the study by Rhoades and Altman (2001) is not strictly a comparison study and the authors use a national database, it is not included in the table. MH = mental handicap. MR/DD = mental retardation/developmental disabilities. S = subject. ICF = Intermediate Care Facility. HCBS = Home and Community Based Services.

though most subgroups showed some cost–benefit, the one group that did not show cost–benefit was the most similar to the current MR/DD institutional population.

Jones, Conroy, Feinstein, and Lemanowicz (1984)

This widely-cited cost-comparison study was conducted as part of the court-ordered Pennhurst Center (Pennsylvania) depopulation effort. In this study the authors reported an average cost difference of between $6,500 and $7,000 in favor of community residential facilities. Despite many citations in the literature, the study does not appear to have generated much critical scrutiny. At the time of the study, approximately 85% of the population of the institution was labeled as having either severe or profound mental retardation. Cost data were compared between a matched sample of 70 "movers" and 70 "stayers." Data on six types of service costs were collected: (a) residential, (b) day program, (c) entitlement (i.e., public assistance levels), (d) case-management costs, (e) medical costs, and (f) other costs. Because Jones et al. collected additional information on costs, their study extends an earlier matched comparison study of behavioral change (Conroy, Efthimiou, & Lemanowicz, 1982).

Despite the prominence of the Jones et al. (1984) study in the literature, there are several methodological problems that may compromise the generalization of findings. Five are cited by the authors: (a) the Pennhurst dispersal was under a court-order and was, therefore, unlikely to have a normative cost structure; (b) subjects were not randomly assigned to groups; (c) all community placements served only 3 or fewer individuals; (d) self-report data on costs from providers in community residential facilities were used; and (e) medical costs were not fully enumerated. In addition, the data-collection design allowed for different methods of data collection across groups. At Time 2 (postrelocation) in this study and its precursor (Conroy et al., 1982), data for 40 of 70 movers (57% of those who moved to community facilities) were collected by "county workers," whereas this was *not* the case for stayers (i.e., those who remained in the institution). Data for stayers were collected by a team of trained workers who used teams of professionals as respondents. Furthermore, those who collected the behavioral data at Time 1 were not the same as those who collected the data at Time 2 for any subjects. Thus, raters were different between Time 1 and Time 2 *and*, for 40 out of 70 movers, were different from those rating all of the stayers at Time 2. In addition, as the authors stated, the interrater reliability of the behavioral data-collection instrument, the Behavior Development Survey, "has been shown to be barely adequate" (Jones et al, 1984, p. 306). Similar problems in methodology appeared in the collection of cost data.

For example, the authors did not explicitly examine the extent to which the different cost-estimation methods in the community and the institution may have yielded systematic biases in the data. In the community, costs were obtained by phone contact, with some costs being based on *estimates* made by one administrator in a county; these estimates were then applied to all individuals in that county. In the institution, by comparison, the operating costs were derived from state billing rates and examination of financial records. These differences in cost-aggregation methods, especially the reliance on broadly applied estimates in community settings, raises the possibility of systematic error. It is noteworthy, given the problems delineated here, that the authors themselves noted difficulties in making valid cost comparisons between community settings and institutions, including the difficulty in capturing costs, the heterogeneity of settings, and the fact that costs can be shifted between the state and federal governments.

More problematic in the present context is that the authors identified "three people living in community facilities with extremely high costs ($77,578, $103,679, and $104,565)" (p. 308) and excluded them, arguing that they were statistical outliers. It is not uncommon for investigators conducting fiscal analyses in human services to find that a small segment of a population accounts for a proportionally large share of costs. Extreme values such as these likely represent *real* costs, despite the fact that in a *statistical* sampling distribution they appear as outliers. Excluding such data may have seriously skewed the cost findings. A better strategy would have been to analyze the data with the so-called "outliers" left in the dataset and then reanalyze the data with the outliers removed, thus allowing comparison of the overall effect of such cases.

Schalock and Fredericks (1990)

In a study comparing the Fairview facility in Oregon with four group homes and an apartment program, Schalock and Fredericks (1990) reported

an average cost of $59,412 in the ICF/MR institutional facility compared to an average cost of $53,635 in community residences. They attributed the average cost difference primarily to staff salary levels and noted that if corrections were made to equalize salary levels, the institutional facility would actually have been less expensive. Certain methodological problems were noted in this comparison as well.

For example, of the 1,048 individuals in Fairview at the time of this study, most had profound disabilities and fewer than 100 (< 10%) were school age, yet all of the community settings but one provided services to children. Furthermore, two of the comparison group homes provided services to children with mild mental retardation and emotional problems or disturbances. When considering only the two group homes serving residents who were most similar to the Fairview population, the community settings are found to be more expensive than the institution (*without* correcting staff salaries). One of these group homes served individuals with severe motor and ambulation problems who were incontinent and who, with the exception of one individual, needed to be fed by a staff member. The other home served children with profound mental retardation, some ambulation problems, and challenging behaviors. The average costs in these two facilities was $60,615, or slightly more than the Fairview average cost. These authors concluded that:

> These data present some troubling facts, especially for staunch advocates of deinstitutionalization. A general conclusion can be drawn from these data that, for individuals with challenging behaviors, residential costs within the community cost approximately the same as institutional services in Oregon, *given the current salary rates of institutional and community residential staff*. When these data are extrapolated, to equalize staff salaries between the institution and the community residence, the conclusion must be drawn that large institutions are, in most instances, less expensive than community residences for these challenging populations. (p. 283, emphasis in original)

Nerney and Conley (1992)

In this large-scale analysis of costs in regions of 3 states (Michigan, Nebraska, and New Hampshire), Nerney and Conley (1992) compared institutional costs and costs in community-based settings (including ICF and non-ICF group homes in Michigan). An array of cost data were collected from community settings, including direct-care and family-care payments (costs of care givers' operations/administrative costs, transportation costs, medical/clinical costs (other than those paid by Medicaid or other third-party payers), day program costs, and other costs. Data were not collected on educational costs or Medicaid-reimbursed health care costs. Data on institutional services in these regions were collected from overall state cost reports. The institutional data were not collected in the same way as the community cost data (i.e., state developmental disabilities offices provided the rates), a methodological problem shared by much of the research in this area.

The overall costs of services to community-based individuals in the specified regions of Michigan, Nebraska, and New Hampshire were $38,098, $19,391, and $28,411, respectively, compared to state rates for institutional care, which were $63,000, $32,000, and $72,000, respectively. The community rates in this study, however, include *both* facility (i.e., group home) and non-facility (i.e., apartment, family, and foster care arrangements). Taken separately, and partially corrected for case mix by examining the 50% of settings with "high need" individuals, the differences between group home rates and institutions in Michigan were reduced to $15,641 (non-ICF) and $14,513 (ICF); in Nebraska they were $6,222; and in New Hampshire, $28,993. Factoring in the Medicaid medical costs and applicable education costs would further attenuate the reported community–institution cost differences.

The interpretation of these findings remains difficult for several reasons. First, data were collected at the level of *facilities* rather than *individuals*. It is likely that there are substantial differences, in each of these 3 states, between the population that resides in their community group homes and the population residing in their institutional settings. It is unlikely that the level of need analysis (a 50% split) fully accounted for such variability (i.e., fully corrected for case-mix factors). Second, as noted, the procedures for aggregating costs differed between the community settings and the institution, and certain costs, as the authors noted, were excluded (e.g., health care costs covered by Medicaid or start-up and capital costs). Third, although the Nerney and Conley (1992) provided separate estimates, the aggregation of all community settings (i.e., facility and nonfacility community settings) de-emphasizes the cost differences *within* community settings. That is, they reported "enormous" variability both within and between states. For example, in Michigan, costs in 11 community place-

ments were under $10,000, whereas costs in 4 others were over $60,000.

In accounting for the differences between community and institutional placements, Nerney and Conley (1992) noted that staffing was a primary variable, given that between 50% and 75% of all of the program costs are associated with staffing. For example, they noted that a substantial portion of the differences in costs between Michigan and Nebraska could be directly attributed to a staffing ratio in Michigan that was 1.62 times higher than in Nebraska.

Knobbe, Carey, Rhodes, and Horner (1995)

Although employing a very small sample (N =11), Knobbe et al. reported a more complete cost-aggregation methodology than is typical in this area. Similar to Schalock and Fredericks' (1990) work, all of the participants had either severe or profound mental retardation and exhibited challenging behaviors and/or mental health problems, thereby providing an interpretive link to current institutional populations. A strength of the Knobbe et al. study is that it is longitudinal; the authors followed the participants who moved from large centralized state facilities to community settings of three individuals each (thereby avoiding case-mix problems). These authors aggregated costs in 16 distinct categories, between 1988 and 1990, including food, medical, utilities, administrative costs, staff training, transportation, insurance, gas/vehicle maintenance, and others. Unlike Jones et al. (1984) and Nerney and Conley (1992), community costs were collected by Knobbe et al. in a way that was similar to how institutional costs were collected. They reported an average yearly cost per resident for the 11 individuals in the community during 1990 as $111,123 compared to their last year in the institution, which cost $117,277 (adjusted for inflation). The difference in costs across the settings was $6,154.

With regard to cost shifting, there was a rather large discrepancy between medical costs in the two settings, with institutional medical costs being more than five times greater than costs in the community ($10,939 vs. $2,144, respectively). The estimate for medical costs in the community settings is low considering health care cost findings in this population. For example, interpolating an annual cost for health care services, for 1990, from available literature (e.g., Adams, Ellwood, & Pine, 1989; Kronick, 1997; Kronick, Dreyfus, Lee, & Zhou, 1996) suggested that a reasonable annualized estimate for all health care costs (i.e., inpatient and outpatient costs) for this population would have been between $4,000 and $4,500, which would account for much (about 38%) of the community versus institution cost difference found in this study.

Although Knobbe et al. (1995) employed a commendable methodology for aggregating costs, we note that neither start-up costs nor capital costs were included in the cost estimates. Nevertheless, these kinds of expenditures are real costs associated with developing community settings and, arguably, should be amortized and entered into the cost-comparison research. Mitchell et al. (1990) noted this issue in their review and commented that it is possible that such costs during rapid deinstitutionalization periods actually cause costs to rise sharply and then return to lower levels. In most of the studies reviewed herein, none of the authors accounted for either community or institutional capital costs or community start-up costs nor was there any correction for costs necessary to pay for state-operated regional and community offices that would not be necessary in an institution-only system.

Campbell and Heal (1995)

Campbell and Heal (1995) employed complex statistical modeling techniques to predict costs of services attributable to facility location, size, funding source, and level of client functioning. They reviewed the literature and indicated that the results of many cost-comparison studies can be challenged because of (a) the difficulty in aggregating costs equitably across community and institutional settings and (b) the lack of comparability in the institutional and community-based groups with respect to functioning level and care needs (i.e., case mix). In their 1995 study, these authors endeavored to address these problems.

Campbell and Heal (1995) examined 1,295 observations in South Dakota of individuals of all ages in 79 *service groups*, which were combinations of different provider agencies, funding sources, and residential service types. Data were collected on average daily costs that were comprised of seven cost centers (administration, support, room and board, etc.); in addition, the analysis included the average daily reimbursement rate for these services as well as staff-to-client ratios. The statistical analysis linked these data to characteristics of service location, agency characteristics, client characteristics, and service funding class as well as to a set of other

demographic variables (e.g., city population, county unemployment rate). A substantial portion of individuals in community settings (29%) were excluded from consideration for various reasons, whereas all but 2 individuals in the two institutions represented were included.

In the analysis, mean average daily costs for the different funding classes, adjusted for community, agency, and client characteristic variables, were (annualized): $55,560 (ICF/MR); $39,077 (ICF/15, i.e., a 15-bed ICF/MR facility); $25,813 (HCBS); and $21,210 (Community Training Services). In a related analysis staff ratios were found to be significantly higher for the ICF/MR settings, which accounted, in part, for the cost differences. Still, the difference across ICF settings (i.e., ICF/MR vs. ICF/15) is striking and suggests that different factors may be included in the cost bases. In addition, certain geodemographic variables (city unemployment rate, population size), along with client functional and behavior characteristics, predicted over 73% of the variance in costs. Adding provider characteristics (e.g., facility size) and funding source (ICF/MR, ICF/15, or HCBS) increased prediction to over 90%. Thus, a great deal of the variability in costs was associated with (a) provider and client characteristics (clients with more intense needs required more expensive services), (b) funding sources, and, interestingly, (c) characteristics of the locale. This last finding echoes the large cost differences across states that was reported by Nerney and his colleagues in the 3 states they studied (Michigan, Nebraska, and New Hampshire).

Exclusive of the institutional placements, Campbell and Heal (1995) found that community services costs bore a U-shaped relation to agency size, with large and small agencies being *more* costly that intermediate-sized agencies. This study, although analytically complex, provides no direct comparisons of costs across comparable groups; rather, the authors sought to predict costs (and other variables) based on a wide assortment of data. Large-scale studies such as this one are important and complement controlled group comparison studies.

One finding of special interest in the Campbell and Heal (1995) study was the strong predictive nature of client characteristics on costs. This finding is in juxtaposition with certain earlier findings. For example, Ashbaugh and Nerney (1990) concluded that client characteristics were *not* related to expenditures. Stancliffe and Lakin (1998) reported a similar lack of relation between expenditures and client characteristics. The finding of a relation by Campbell and Heal, however, is important, because predicting 65% of the variance in costs shows that client characteristics *do* matter in service costs.

Stancliffe and Lakin (1998) and Stancliffe and Hayden (1998)

In these two studies, both conducted at the University of Minnesota, the authors drew their participants from 190 individuals enrolled in an ongoing longitudinal study. Expenditures and outcomes for 116 individuals with severe and profound cognitive impairments following movement to community settings and 71 individuals who remained in institutional facilities were studied. Stancliffe and Hayden (1998) followed the 71 individuals who did not move to community placements. Because cost analysis is rather secondary in the Stancliffe and Hayden study, our focus here will be the study by Stancliffe and Lakin (1998) in which "movers" and "stayers" were compared.

Although Stancliffe and Lakin (1998) made comparisons based on residential costs as well as total costs (residential costs + day program costs), comparisons between community and institutional settings were only conducted on total costs due to the aggregation methodology. These comparisons were reported for both raw and adjusted data using resident:staff ratio as a covariate, based on staff members available on weekday evenings. Stancliffe and Lakin reported significant differences in both raw and adjusted average daily total expenditures between community and institutions. Costs for residents in community settings (annualized: $84,475) were 36% less than costs for residents in institutional settings (annualized: $115,168).

Some of the problems identified in this research area, such as case-mix issues, appear to be resolved by the use of statistical analyses using covariates. However, taken together, statistics from both of these articles (Stancliffe & Hayden, 1998; Stancliffe & Lakin, 1998) suggest that certain selection factors may still have been operating that affected the outcomes and conclusions. For example, it appears from the data that a behaviorally challenging group may have been initially overlooked for community placement, requiring the state to develop public community ICF/MR settings. In addition, Stancliffe and Hayden presented statistics on therapy use in the stayers group, suggesting that many of them had severe physical dis-

abilities. It is possible that some of these differences were not apparent in significance testing due to the reactivity of certain measures (e.g., using the ICAP Broad Independence score as a measure of adaptive behavior).

In addition, one of the variables used as a covariate, resident:staff ratio on weekday evenings, may have unduly penalized the institution relative to the community sample. Differences in staffing ratios across the day may simply be a proxy for differences in setting characteristics. For example, it is likely that the assessment of *overall* resident:staff ratios would have attenuated setting differences because in ICF/MR settings, there are many therapists available during the day that cannot be counted on weekday evenings. In an ICF/MR setting with residents who have multiple disabilities and restricted functioning, many resident training programs are likely to be active during the day, when specialized staff members are available to carry them out.

It is also the case that staffing levels in public ICF/MR settings that are slated for downsizing or closure may not be representative of typical staffing ratios. It is likely that, due to civil service rules, unionization, and so forth, that a lag exists between the reduction in census and the reduction in staff. In the studies conducted by Stancliffe and his colleagues, data were collected during a 4-year transition period as staffing levels were adjusted down in the institution and up in the community to accommodate the shift in consumers. Because staffing reduction in institutional settings almost certainly proceeds slower than staffing up in community settings, staffing ratios in these studies may be somewhat suspect and, as a covariate, are likely to have affected many of the analyses.

Finally, the exclusion of medical, case management, and capital costs no doubt affected the comparisons. We have already addressed the issue of the medical costs shifting from ICF/MR costs to other sources (e.g., private insurance, Medicaid fee-for-service). However, given the complexities of the community-based population described in these studies, it is not unreasonable to conclude that *additional* case management costs would accrue in the non-ICF/MR settings compared to the institution and community ICF/MR settings.

International Cost-Comparison Research

Although the main focus of the present review is the United States, there is a substantial body of literature from other countries that cannot be ignored. This literature is, in some ways, strikingly different than the American literature. Felce (1994) reviewed the research on cost studies in the United Kingdom and explored what he characterized as a consistent finding that community services were more expensive than institutional services, in juxtaposition to the perception of many in America. For example, Emerson and his colleagues, who also studied costs in the United Kingdom, cited a previous meta-analysis that "adjusted costs. . . reported for hospitals [institutions] ranged across studies from $799 to $1,540 per week, whereas costs reported for group homes ranged from $912 to $2,750 per week" (Kavanagh & Opit, 1998, quoted in Emerson et al., 2000, p. 83, material in brackets added). Underlying the differences in cost-comparison research in the United Kingdom and America may be differences that exist in the service systems. For example, in America states share costs with the federal government in complex ways that promote cost shifting as state systems expand community systems relative to institutions. Because the costs that can be shifted under Medicaid programs differ and are not clearly understood by many, a perception may have arisen that there is no diseconomy of scale in smaller facilities. In contrast, because funding formula are less complex in the United Kingdom, it is assumed that community care will be more costly; in some ways just the opposite of the American view.

Still, Felce (1994) concluded that smaller community-based facilities offer the potential for increases in certain aspects of quality of life and that, in the long run, may be economically affordable. However, he cautioned that very small placements (i.e., smaller than 4) may not be able to maintain favorable costs structures if additional staff members are required based on increased needs of residents.

Recent work in the United Kingdom by Emerson and his colleagues (Emerson et al., 2000) found that costs associated with dispersed housing (i.e., housing that is integrated into existing communities) were 15% higher than those of residential campuses (i.e., institutions) and were 20% higher than village communities (i.e., clustered housing similar, in some ways, to regional centers and certain private facilities in America). After the authors adjusted for both adaptive behavior and challenging behavior, the annualized per person cost in 1997–1998 dollars (converted at £1 = $1.63) for village communities was $71,604; for residential campuses,

$74,516; and for dispersed housing in the community, $85,852.

In a multivariate study conducted by Felce and his colleagues in Wales (Felce et al., 2000), total accommodation costs were predicted from resident and setting characteristics, setting size, service processes, and indicators of quality. These researchers derived a two-factor regression solution predicting accommodation costs that included service model and client characteristics (Adaptive Behavior Scale [ABS] scores) that accounted for 51% of the variance in costs, adjusted $R^2 = .48$. Unlike the findings in America, costs in this model were found to be *lower* for institutions in comparison to community settings. Similar to some of the research conducted in the United States, client characteristics were important in predicting costs. According to Felce et al., the cost differences between service models were related to client characteristics, such that "costs tended to be higher for people with lower ABS scores within each service model... (and that) the consistent finding of UK research on deinstitutionalization is that community services are more expensive than institutional services" (p. 321).

At present, there is speculation as to what forces produce this juxtaposition of cost differences between the United Kingdom and the United States. Stancliffe, Emerson, and Lakin (2000) suggest that "one factor contributing to higher institutional costs in US studies may be that many US institutions have been downsized to the extent that relatively fixed institutional infrastructure and running costs are distributed over a small and diminishing population" (p. iii). This is precisely the interpretation offered by Braddock et al. (1991). This view is further echoed by Felce and his colleagues and has been voiced elsewhere in the literature. In addition, the work by Felce and his colleagues (2000) also assessed quality of life and noted that "This analysis provides additional evidence of a weak linear relationship between resource inputs and service quality, even after controlling for service recipient characteristics" (p. 323).

Rhoades and Altman (2001)

Using data from the 1987 National Medical Expenditure Survey (NMES), Rhoades and Altman (2001) used a different approach to studying costs in MR/DD services. In this survey, instead of taking the typical perspective of average aggregated costs from samples of individuals across settings, they derived data at the *individual* level. That is, individuals were sampled, and then asked about their individual costs. Rhoades and Altman began by noting that despite the success of deinstitutionalization, problems remained, including (a) the more intense needs and, thus, associated increased costs, of those who remain in congregate care facilities and (b) the declining cost–benefit of community settings compared to institutional settings. These problems prompted the recognition that now that the field has effectively deinstitutionalized many individuals, "the remaining population, more likely to have multiple problems, is generally a population that would generate higher expenditures no matter where they are located" (p. 115).

From this perspective Rhoades and Altman (2001) conducted a multiple regression analysis that, among other things, predicted mean daily expenditures by several categories of person variables and facility characteristics. The authors extended the work done by researchers such as Campbell and Heal. Rhoades and Altman reported that:

> The results of the multivariate analysis indicate, at a national level, what Campbell and Heal (1995) found in South Dakota. Facility characteristics, resident characteristics, and even community resources play a part influencing daily expenses for residents in facilities both large and small.... The results also show that for persons with borderline, mild, moderate, or severe levels of mental retardation, it is more expensive to provide care in larger facilities. For individuals with profound mental retardation, the size of the facility is not a factor in daily expenses once the increased expenses for the level of mental retardation are considered. (pp. 123–124)

In a way, the Rhoades and Altman study (2001) was the beginning of the shift in the literature away from controlled comparison studies. Instead of using static comparisons to determine specific costs in a policy-making context, results of this study suggest that researchers should approach the problem from the perspective of the individual and identify the most favorable placement based on the characteristics of the person and the service setting together. The authors showed, for example, that resident characteristics were, indeed, associated with costs of care regardless of the setting. Perhaps even more interesting is the interaction with level of mental retardation such that "Persons with similar levels of dependence had different daily expenses, related to their level of mental retardation and, thereby, the ability to cooperate and communicate with caregivers" (p. 126). This work is important because the results suggest questions that relate specific needs of individuals to specific re-

quired services independent of the setting. Again, in the words of Rhoades and Altman:

> It is important to understand how organizational type, resident characteristics, number and types of services, and location come together to influence expenditures in order to develop the necessary resources for proposed health care delivery plans. Examining expenses from the individual rather than the organizational perspective allowed us to examine this complicated puzzle in a different way. (p. 127)

In such a context the question: "What costs more, community or institutions?" or "Which type of setting serves an individual better?" is no longer the critical question. Adopting the approach implied by Rhoades and Altman (2001), it becomes clear that costs and expenditures are related to the needs of the person, the quality of services provided, the desired outcomes, and perceived satisfaction on the part of the individual.

A Word on Outcomes

Although we are aware that the issues of quality of services and service outcomes necessarily go hand in hand with costs, the empirical association between costs and quality is less established when a broad array of research findings are examined. For example, positive outcomes reported in the literature associated with deinstitutionalization and community-based services include increased choice (Stancliffe, 2001; Stancliffe & Abery, 1997), behavioral improvement (Kim, Larson, & Lakin, 2001), improved social interaction of certain segments of the population (Anderson, Lakin, Hill, & Chen, 1992), integration in rural settings (Campbell, Fortune, & Heinlein, 1998), and inclusion in various day-to-day activities (Campo, Sharpton, Thompson, & Sexton, 1997; Emerson et al., 2000). However, such positive findings need to be considered in relation to findings of increased mortality in community settings (Strauss & Kastner, 1996; Strauss, Kastner, & Shavelle, 1998; Strauss, Shavelle, Baumeister, & Anderson, 1998; see also Taylor, 1998), problems in vocational services and employment (Stancliffe & Lakin, 1999), and problems of Individual Habilitation Plan objectives and behavioral technology (Stancliffe, Hayden, & Lakin, 1999, 2000). Recent work has also highlighted problems in access, utilization, and quality in community-based health care and personal care for people with mental retardation and developmental disabilities (Knobbe et al., 1995; Larsson & Larsson, 2001; Walsh & Kastner, 1999). Emerson and his colleagues (2000) identified higher rates of verbal abuse and relatively greater exposure to crime among individuals who lived in dispersed community settings. Finally, Felce and Perry (1997) reported that in the community settings they studied, staff members generally lacked organized approaches and skill sets to promote development in those living in the settings in which they worked.

Although the assessment of consumer satisfaction and quality of life has been reported often in HCBS settings, in other evaluation reports, investigators (e.g., Lutsky et al., 2000) have noted a set of specific concerns around quality of care, as did LeBlanc et al. (2000). As stated by Lutzky and his colleagues, these concerns include (a) difficulty in state monitoring of noninstitutional care because of their dispersed nature, an increasing problem as more HCBS placements have been created; (b) inexperience in monitoring noninstitutional care, in some states including a lack of regulations and licensing requirements; and (c) the potential impact of low provider reimbursement rates on the quality of care. In the words of Lutsky et al. (2000): "The effectiveness of licensing and regulatory requirements at ensuring quality of care is impaired if states do not sufficiently monitor compliance. However, monitoring quality of HCBS services may present greater challenges than monitoring quality in institutional settings" (p. 28).

It may also be the case that quality of *care* and quality of *life* differ across community and institutional settings in their importance to stakeholders. For example, as institutions increasingly provide services to people with severe and profound cognitive deficits, complex needs, challenging behaviors, and diminishing skills, concerns about quality of *care* may outweigh those of satisfaction. In community settings, on the other hand, with a more heterogeneous and able population, it may be that quality of life, satisfaction, and interest in self-determination takes on more importance. Thus, the assessment of *both* quality of care and quality of life, although related and important in both settings, may need to be adjusted for characteristics of the setting in which they are assessed.

Therefore, we agree with Emerson (1999) that outcome measurement be expanded beyond assessment of personal outcome measures, such as choice and community involvement, to include a greater emphasis on health and safety. As Walsh and Kastner (1999) have pointed out, health and safety outcomes have been underrepresented in the MR/DD

literature (cf. Hughes, Hwang, Kim, Eisenman, & Killian, 1995). Outcome measurement needs to include direct indicator and benchmark assessment of outcomes based on clear standards. For example, individuals with profound disabilities and multiple disabling conditions may benefit from measures evaluating (a) access to comprehensive health care services (primary, psychiatric, and dental care as well as ancillary services, including care coordination); (b) rates and status of abuse/neglect reports and investigations (including victimization in the community); (c) mortality review; (d) access and utilization of behavioral services; and (e) similar direct measures.

Discussion

In this review of selected peer-reviewed studies, we have documented the complexity of research examining costs of community and institutional service models and show how methodological problems affect conclusions. The work reviewed here spanned a quarter-century during which time the field was in constant transition. Early studies were designed simply to show the cost–benefit of community placements (e.g., Murphy & Datel, 1976), whereas more recent work has highlighted the complex multivariate nature of the area and recognized the need to identify costs at the individual level (Rhoades & Altman, 2001). The shifting cost structures across settings during the period reviewed, and the heterogeneity of the population served, prompts the conclusion that the question "Which is less expensive, institution or community?" is the wrong one to ask. Rather, the questions that need to be asked revolve around the individual (i.e., What does this person need? Where is the best place to provide for these needs?" and "at what cost?").

The research reviewed here suggests, in several ways, that community placements are not inherently less expensive than institutions. First, there is an intrinsic lack of comparability between institutions and community settings. For example, community services include a diverse array of service *types*, ranging from minimal intermittent supports to residential and day program services, whereas institutions traditionally offer an established service *package* (e.g., ICF/MR services). Thus, only a part of the range of community services is comparable with the services received in a large ICF/MR. Researchers comparing costs need to assure that the service packages are comparable across settings, a challenge given the inherent differences in these service systems. Second, during deinstitutionalization efforts, the ability to shift certain community costs to programs other than those administered by a particular MR/DD state agency will lead to reduced costs *within* that specific governmental division or authority. However, the overall cost to society may not be reduced. For example, medical costs within an ICF/MR are clearly part of the budget of the state MR/DD authority; however, when an individual moves to a community setting, medical expenses can often be shifted to another funding source (e.g., the component of state government that administers Medicaid health care benefits). Third, the apparent cost savings in community settings, to the extent that it is found, is often directly related to staffing costs. Results of the research reviewed herein suggest that the modest differences reported for community services are predominantly the result of lower staffing costs in privately operated community settings compared to state-operated settings. However, the lack of parity between staffing costs in institutions and community settings is not a desired efficiency. In fact, it is likely that any initial cost benefits claimed for community settings will be difficult to sustain as individuals with more complex needs are served in these settings. Further, over time, it is possible that the disparity between community and institutional cost structures for staffing will diminish as community workers and advocates strive to achieve parity in compensation with respect to state workers. Results of the present study suggest that the area of staff compensation deserves further study.

These elements of complexity in community–institution cost comparisons give rise to several recurring methodological problems. These problems include (a) the lack of comparability between groups based on biased, nonrandom, or convenience samples; (b) the lack of adequate case-mix controls; (c) differences in data-collection and cost-aggregation methods across groups; (d) the exclusion of critical categories of costs, such as medical expenses, case management, start-up, and capital costs; and (e) extreme variability in costs, cost shifting, and statistical-modeling problems.

These methodological problems limit generalization across settings. Three especially challenging methodological problems deserve special mention. First, few of the studies reviewed herein completely accounted for case-mix factors. Given the heterogeneity of the population of individuals with MR/

DD and the near impossibility for random assignment to residential settings, complex case-mix factors are always present. Longitudinal studies and multivariate studies using statistical controls (e.g., employing covariate methods) offer promise as long as care is exercised in the selection of variables. Ideally, covariates that include both cognitive and adaptive measures should be included, although this was not typical of the studies we reviewed.

Second, cost-aggregation methods varied widely over the reviewed studies. Often, the cost-aggregation method used in community settings was different than the way costs were identified in facility settings. In our review, researchers who employed more complex and complete cost-aggregation methods typically found smaller, if any, community–institution differences. In studies from the United Kingdom, which seem to be less susceptible to methodological artifacts (such as cost shifting or inability to estimate costs), researchers typically reported increased costs in community settings.

Third, elements of costs were routinely excluded in even the best studies reviewed here, sometimes because they were shifted to other funding sources and sometimes because the data were unavailable. In both cases it is not acceptable to assume that the effects of costs that are shifted or excluded are the same in the comparison groups. We have noted, for example, that many service costs are *built into* the ICF/MR model. The costs incurred for supporting community infrastructure for such costs cannot simply be excluded from the cost-comparison analyses. Related to this, an inherently difficult fiscal problem is the inclusion of start-up and capital costs incurred in community settings compared to long-term state ownership of institutional facilities. Excluding these categories of costs is not justifiable, and researchers need to identify methodologies that include these costs (e.g., Emerson et al., 2000). In conclusion, in nearly all of the studies reviewed, certain specific costs were excluded from the analyses, thus limiting the generalization of results.

From the cost studies reviewed here, it is clear that large savings are not possible within the MR/DD field. That is, the costs of residential care, regardless of setting, involve a specific amount of resources that vary, somewhat predictably, with staffing levels, client characteristics, and other variables as in the studies reviewed. These studies do not support the view that large cost savings are possible. In fact, researchers who conducted the studies reviewed here that employed more sophisticated and complete cost-aggregation methods tended to find the smallest differences across settings (e.g., Knobbe et al., 1995; Schalock & Fredericks, 1990).

Although this review provides a unique historical overview of research in this area, it is not without limitations. First, we restricted our selection of studies to those that were peer-reviewed and addressed the issues under consideration. We narrowed our selection to peer-reviewed studies for quality control reasons and because, for example, unpublished state-level reports might be especially susceptible to cost-shifting effects. A cursory review of many of these reports, however, suggested that their inclusion would not substantially alter our conclusions. Second, we did not directly review the outcomes literature, although, as we have noted, we believe it to be critically important in this field. Third, the scope of this work did not allow us to review cost comparisons made between different community settings, although published work is beginning to appear in this area and will prove to be more critical in the future. We believe that the methodological considerations presented herein will continue to be important as that literature grows.

In the final analysis, it appears that the costs of caring for people with MR/DD will be highly variable across settings and will vary with the characteristics of those served and the resources, especially staffing, devoted to serving them. Because this population ranges from individuals who are barely distinguishable in the general population to individuals who require high levels of sophisticated care, it is likely that a range of service models will continue to be needed. In the future, researchers who conduct studies that will best inform public policy are likely to be those employing multivariate methods to take such heterogeneity into account. As we have documented here, movement toward such research models is already underway.

Based on the analysis presented here, the choices made by governmental agencies about the relative mix of service types should include a consideration of consumer needs rather than being made solely on the basis of local service costs. It is also important to take into account the values of those who use the services.

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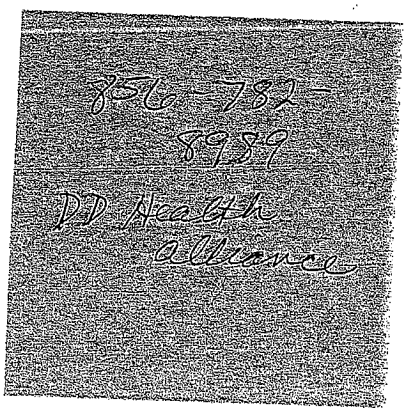

Testimony: Opposition to Kansas Neurological Institute
Senate Public Health & Welfare Committee
March 2, 2011
By: Christy Caldwell, Vice President Government Relations
Greater Topeka Chamber of Commerce
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Greater Topeka
CHAMBER & GO TOPEKA

Chairwoman Schmidt, members of the Committee, thank you for the opportunity to address you regarding the proposed closure of KNI in Topeka.

KNI is a shining example of the state's compassionate care of 156 very fragile Kansas citizens who live in group homes within, what was once, a state institution here in Topeka. Eighty-eight percent of the population living at KNI are profoundly disabled, many with multiple disabilities. These sons and daughters of Kansas residents have come to KNI from all regions of the state, (actually there are 31 counties represented). There is no doubt their care is expensive; their needs are 24/7 and sometimes they require immediate special attention. Without the high quality care provided by KNI, we are concerned for their future.

The proposed 2012 budget mandates they be absorbed into community care somewhere within the state over time. The Topeka Chamber is very concerned that there are not enough locations that have a full array of services necessary to support these fragile people. We are being told that moving residents out of KNI will save the state money. Yet, we have those who indicate quality housing and services for clients with such significant needs are not currently available. To replicate what now exists at KNI will certainly be very costly.

Most residents have lived in their KNI home for many years and relate to those who care for them as family members. Deliberations to force them from their home, is devastating to their families and guardians. We understand none of the committees reviewing this issue have been provided a list of facilities with available space, appropriate specialized equipment and quality trained staff for KNI residents? We are not convinced such housing is readily available here or throughout the state and believe this proposal will only result in cost shifts to provide what is already existing at KNI, we doubt there will be any cost savings.

These fragile Kansans need care around the clock; they need specialized medical & dental care, they need appropriate transportation, special equipment, equipment maintenance, appropriate food and special means to provide nourishment. KNI has such medical services, equipment, and transportation; we are not convinced community-based facilities have this level of care available without significant new spending.

KNI staff is provided specific training to serve the needs of their residents, with that training their wages are $12.35/hour and they receive a full range of benefits. Community-based services are reported to hire workers at $8.83/hour with limited benefits. Training provided is not at the same level provided to KNI workers. We are concerned with the lack of appropriate training and the the turnover rate at community-based facilities. This trained staff is already available at KNI for residents who have spent much of their adult lives with staff they now consider family.

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Greater Topeka
CHAMBER & GO TOPEKA

At a hearing before the House Budget Committee, advocates for community-based placement of KNI residents drew a comparison of the potential closure of KNI to the closure of Winfield in the late 1990's. We listened to testimony regarding a study conducted over a ten year period. This study indicated persons removed from Winfield and placed in the community had significant improvement in their quality of life and health. What was not related to the House Committee was that KNI residents had comparable or even higher quality of life and health improvements during the same 10-year study period and have continued to show progress.

The Topeka Chamber commissioned an economic impact analysis of KNI on Topeka, for the State Closure Commission in 2009. This study was completed by Impact Data Source, Austin, TX. It is attached to my testimony.

KNI had a significant impact on the Topeka area economy during FY 2010. KNI's revenues and expenditures and its employees and their salaries provide direct economic activity. In addition, this activity ripples through the area's economy supporting indirect benefits including sales at local businesses and organizations, as well as indirect jobs and salaries. There are three methods highlighted below. Loss of KNI will have a significant impact on this community, including effectively increasing the unemployment rate and the need for state services to assist these employees and their families. We doubt this consequence has been computed into the savings the state is expecting to realize.

- The estimated direct economic impact KNI had on your capital city's economy, in FY 2010, was $28 million. The direct revenues of KNI, spending and the spending of its workers generated another $37 million in sales or economic output in area businesses and other organizations. In total the economic impact of KNI in FY 2010 was $66 million.

- While the Institute employs 570 individuals, KNI's spending and the spending of its workers support another 741 jobs in this community. In total, the Institute supports 1,311 area jobs.

- Similarly, while the salaries and other payroll cost of the Institute's employee totaled $27 million in FY 2010, KNI's spending and the spending of its workers supported another $35.2 million in salaries for workers in related spin-off jobs supported in the area. Therefore the total salaries and other payroll costs supported by KNI during 2010 was a total $62.3 million. (Three copies of the analysis have been made available to the chair of the committee.)

If the motive for closing KNI is saving the state dollars, we respectfully ask your very careful consideration of whether there are real cost savings or cost shifts. We ask that you listen to those who know the residents of KNI the best – their families, care-givers and the medical community. The Greater Topeka Chamber of Commerce urges your decision to be that KNI group homes and support services continue to serve our state's most needy.

Thank You

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A Report of the Economic Impact During Fiscal Year 2010 of the Kansas Neurological Institute in Topeka, Kansas

September 19, 2009

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Executive Summary

This report presents the results of an economic impact analysis performed by Impact DataSource, an Austin, Texas economic consulting and research firm. The purpose of the analysis was to determine the impact that the Kansas Neurological Institute had on the economy of the Topeka area during fiscal year 2010 (July 1, 2009 to June 30, 2010). The related revenues for City of Topeka and other local taxing districts were also calculated.

The Institute

The Kansas Neurological Institute, located in Topeka, Kansas, is a state hospital for patients with intellectual disabilities and a component of the Kansas Department of Social and Rehabilitation Services.

The Institute opened on January 5, 1960, with the admission of its first six residents. By November 1960 approximately 200 people had been admitted.

On October 1, 2008, the Institute had 163 residents.

The Institute has 373,688 square feet of buildings and 156,257 square feet of homes for residents on a 180.5 acre site.

During fiscal year 2009, the Institute received funding of $28.7 million. During fiscal year 2010, the facility had 570.2 full-time equivalent employees and annual payroll costs of $27 million.

Economic Impact during Fiscal Year 2010

The Institute will have a significant impact on the Topeka area economy during fiscal year 2010. The Institute's revenues and expenditures and its employees and their salaries provide direct economic activity. In addition, this activity will ripple through the area's economy supporting indirect benefits including sales in local businesses and organizations, as well as indirect jobs and salaries.

The estimated direct economic impact of the Institute in fiscal year 2010 was $28 million. The direct revenues of the Institute, its spending and the spending of its workers will generate another $37 million in sales or economic output in area businesses and other organizations. In total, the economic impact of the Institute in fiscal year 2010 will be $66 million.

While the Institute employed 570.2 individuals, the Institute's spending and the spending of its workers support another 741 jobs in the area. In total, the Institute supports 1311.2 area jobs.

Similarly, while the salaries and other payroll costs of the Institute's employees total $27 million in fiscal year 2010, the Institute's spending and the spending of its workers will support another $35.2 million in salaries for workers in related spin-off jobs supported in the area. Therefore, total salaries and other payroll costs supported by the Institute during the year will total $62.3 million.

This economic output and related jobs and salaries supported by the Institute are responsible for significant retail sales in the area, spending on lodging and residential property owned or occupied by Institute employees and indirect workers on local tax rolls. These taxable retail sales, spending on lodging and residential property are shown below.

Taxable Retail Sales, Spending on Lodging and Residential Property on Area Tax Rolls Supported by the Institute in Fiscal Year 2010	
Taxable annual retail sales in the area	$20,832,963
Taxable value of residential property owned or occupied in the Topeka area by Institute employees and indirect workers	$189,143,264
Annual spending by out-of-town visitors on lodging	$9,500

The economic activity generated by the Institute translates into substantial revenues for local taxing districts.

Revenues for Local Taxing Districts

The City of Topeka and other local taxing district will receive the following revenues during fiscal year 2010 as a result of the Institute's presence in the community.

Estimated Revenues for the City of Topeka and Other Local Taxing District During Fiscal Year 2010 as a Result of the Institute's Presence in the Community	
Local sales taxes received collected by local taxing districts	$447,909
Local hotel occupancy taxes collected by the City of Topeka	$190
Property taxes collected on residential property	$3,283,465
Total	$3,731,564

Details of this analysis are on the following pages.

A Report of the Projected Economic Impact of the Kansas Neurological Institute

Introduction

This report presents the results of an economic impact analysis performed by Impact DataSource, an Austin, Texas economic consulting and research firm. The purpose of the analysis was to determine the impact that the Kansas Neurological Institute had on the economy of the Topeka area during fiscal year 2010 (July 1, 2009 to June 30, 2010). The related revenues for City of Topeka and other local taxing districts were also calculated.

The report presents the following information:

- A description of the Institute,
- The economic impact of the operations of the Institute during fiscal year 2010,
- Annual revenues received by local taxing districts as a result of the Institute's presence in the city,
- An explanation of how the analysis was conducted and some information on Impact DataSource, the firm that conducted this analysis.

A description of the Institute is next.

Description of the Institute

The Kansas Neurological Institute, located in Topeka, Kansas, is a state hospital for patients with intellectual disabilities and a component of the Kansas Department of Social and Rehabilitation Services.

The Institute opened on January 5, 1960, with the admission of its first six residents. By November 1960 approximately 200 people had been admitted.

On October 1, 2008, the Institute had 163 residents.

The Institute has 373,688 square feet of buildings and 156,257 square feet of homes for residents on a 180.5 acre site.

Annual Funding

During fiscal year 2009, the Institute had the following funding:

Annual Funding for the Institute	
Revenue (Medicaid)	$11,112,811
Fee Fund - Other	$1,181,122
State Appropriations	$15,951,318
Other Funds	$491,622
Total	$28,736,873

Source: Kansas Neurological Institute,
http://srskansas.org/kni/Other%20Information/Statistics.htm

Number of Workers and Annual Salaries

During fiscal year 2010, the Institute had the following number of workers and annual payroll:

Number of Workers and Annual Payroll Costs			
	Full-Time Equivalent Number of Workers	Average Annual Salaries	Total Annual Salaries
Non-professional employees	456	$28,639	$12,927,065
Professional employees	114.2	$54,041	$5,641,016
Total salary payments	570.2	$32,564	$18,568,081
Additional payroll costs:			
Resident workers' salaries			$171,788
Fringe benefits			$7,618,560
Holiday pay			$207,791
Longevity bonuses (all eligible employees			$288,800
Shift differential pay primarily for non-professional			$237,146
Total number of workers and payroll costs	570.2		$27,092,166

Source: Kansas Neurological Institute

Where Employees Live

According to the Institute, there are currently 487 Institute employees who are Shawnee County residents (92.8% of total employees) and 38 who reside in other counties (7.4%).

The annual economic impact of the operations of the Institute are discussed next.

The Economic Impact of the Operations of the Institute During Fiscal Year 2010

The Topeka area receives substantial economic benefits from the operations of the Institute. These economic benefits include the following:

- Revenues of the Institute and revenues for area businesses and other organizations,
- Jobs,
- Workers' salaries or personal income,
- Local worker spending, and
- Visitor spending.

These economic impacts may be characterized as direct, indirect and induced, as discussed next.

Types of Impacts that the Operations of the Institute Provide

Direct, Indirect and Induced Economic Impacts

The direct economic impact comes from the operations of the Institute and its employees. From the revenues and spending of the Institute and its employees, indirect and induced benefits or spin-off benefits are supported in the area.

Indirect sales, jobs and salaries are supported in area businesses and organizations, such as food distribution companies, air conditioning service firms, office supply firms, etc. that supply goods and services to the Institute. In addition, induced sales, jobs and salaries are supported in area businesses or organizations, such as restaurants, gas stations, banks, book stores, grocery stores, apartment complexes, convenience stores, computer stores, service companies, etc. that supply goods and services to the Institute's employees and their families and, in turn, to workers in indirect jobs and their families.

To estimate the indirect and induced economic impact of the Institute and its employees on the Topeka area, regional economic multipliers were used. Regional economic multipliers for Kansas and areas of the state are included in the US Department of Commerce's Regional Input-Output Modeling System (RIMS II).

Three types of regional economic multipliers were used in this analysis:

- An output multiplier,
- An employment multiplier and
- An earnings multiplier.

An output multiplier was used to estimate the additional sales or output created by the Institute in area businesses or organizations. An employment multiplier was used to estimate the number of indirect and induced jobs created and supported in the Topeka area by the Institute. Similarly, an earnings multiplier was used to estimate the amount of salaries paid to workers in these indirect and induced jobs.

The multipliers show (1) the estimated sales or output in area businesses or organizations for each dollar of revenue received by the Institute, (2) the number of indirect and induced jobs created for every one direct job at the Institute and (3) the amount of salaries paid to these workers for every dollar to be paid to an employee of the Institute.

A multiplier of 1.3 was used in this analysis. This means that for every dollar of revenue that the Institute receives, there is $1.30 in sales or output in area businesses or organizations. Similarly, for every dollar paid to employees at the Institute there is $1.30 paid to workers in spin-off jobs created in the area. Further, for every employee at the Institute there are an additional 1.30 workers supported in spin-off jobs in the area.

The Economic Impact of the Operations of the Institute During Fiscal Year 2010

As stated before, during fiscal year 2009, the Institute had an annual revenues of $28,736,873 and 570.2 full-time employees and annual payroll costs of $27,092,166 in fiscal year 2010.

Since fiscal year 2010 has not been completed, this analysis assumes that fiscal year 2010 revenues will be the same as 2009 revenues.

This activity generated the following direct and indirect economic activity in the area during fiscal year 2010:

Economic Output, Jobs, and Annual Salaries Supported by the Institute in Fiscal Year 2010			
	Economic Output	Jobs	Salaries
Direct	$28,736,873	570.2	$27,092,166
Indirect and induced	$37,357,935	741	$35,219,816
Total	$66,094,808	1311.2	$62,311,982

As shown on above, the estimated direct economic impact of the Institute in fiscal year 2010 was $28 million. The direct revenues of the Institute, its spending and the spending of its workers will generate another $37 million in sales or economic output in area businesses and other organizations. In total, the economic impact of the Institute in fiscal year 2010 will be $66 million.

While the Institute employed 570.2 individuals, the Institute's spending and the spending of its workers support another 741 jobs in the area. In total, the Institute supports 1311.2 area jobs.

Similarly, while the salaries of the Institute's employees total $27 million in fiscal year 2010, the Institute's spending and the spending of its workers support another $35.2 million in salaries for workers in related spin-off jobs supported in the area. Therefore, total salaries supported by the Institute during the year will total $62.3 million.

Out-of-Town Visitors to the Institute

The Institute has some out-of-town visitors during the year including visitors to patients and other visitors.

The estimated number of out-of-town visitors to the Institute and their spending during the year are shown below.

Number of Out-of-Town Visitors to the Institute during Fiscal Year 2010 and Their Spending in the Community	
Estimated number of other out-of-town visitors during the year	100
Average days' stay of each visitor	1.5
Average daily retail spending by each out-of-town visitor	$50
Average nights stay by each visitor	1
Average nightly room rate at a local motel	$95
Total retail spending	$7,500
Total number of room nights	100
Total spending on lodging	$9,500

As shown above, out-of-town visitors to the Institute spent about $7,500 in the community during fiscal year 2010 eating in local restaurants and shopping in local stores and another $9,500 staying overnight at local motels. In total, out-of-town visitors to the Institute spent $17,000 in the Topeka area during fiscal year 2010.

Revenues for the City of Topeka and Other Local Taxing Districts during Fiscal Year 2010

The City of Topeka, as well as other local taxing districts, will receive substantial tax revenues from the Institute, its employees, and workers in indirect jobs supported in the area and out-of-town visitors.

Some Tax Rates Used in this Analysis

Some tax rates included in this analysis are shown below.

Some Tax Rates Used in this Analysis	
Sales tax rate:	
City of Topeka	1%
Shawnee County	0.5%
Washburn University	0.65%
Estimated transit guest tax allocated to the City of Topeka	2%
Mill levies:	
City of Topeka	32.682
Shawnee County	40.117
Average levy for Auburn/Washburn Unified School District 437 and other districts	50.881
Topeka Transit	3.000
Metropolitan Topeka Airport Authority	1.09
Washburn University	3.316
Topeka & Shawnee County Public Library	8.999
Classification rate Real property used for residential purposes	11.50%
Effective property tax rate as a percent of the appraised or market value of residential property:	
City of Topeka	0.3758%
Shawnee County	0.4613%
Average levy for Auburn/Washburn Unified School District 437 and other districts	0.5851%
Topeka Transit	0.0345%
Metropolitan Topeka Airport Authority	0.0125%
Washburn University	0.0381%
Topeka & Shawnee County Public Library	0.1035%

Taxable Spending in the Area

Annual taxable spending by the Institute's employees, workers in spin-off jobs supported in the community and visitors' spending will account for the following retail sales in the Topeka area during the year:

Taxable Local Retail Spending Supported by the Institute in Fiscal Year 2010		
	Total Salaries, Spending or Sales	Taxable Retail Spending (36% of an Employee's Salary
Employees at the Institute	$27,092,166	$9,753,180
Workers in indirect and induced Jobs	$35,219,816	$12,679,134
Out-of-town visitors	$17,000	$17,000
Percent of spending in Shawnee County		92.8%
Total	$62,328,982	$20,832,963

Residential Property on Local Tax Rolls

As stated before, there are currently 487 Institute employees who are Shawnee County residents (92.8% of total employees) and 38 who reside in other counties (7.4%).

Although the Institute's property is not on local tax rolls, employees and workers in spin-off jobs in the community own or occupy residential property on which they directly or indirectly pay property taxes, as shown below.

Market Value of Residential Property Owned or Occupied by Institute Workers and Indirect Workers in Fiscal Year 2010	
Number of direct and indirect workers supported by the Institute	1,311
Estimated percent of employees who live in Shawnee County	92.8%
Estimated average market value of residential property owned or occupied by workers	$155,444
Total taxable value of residential property owned or occupied in the Topeka area by the Institute's direct and indirect workers	$189,143,264

Annual tax revenues for the City of Topeka and other local taxing districts are discussed next.

Local taxing districts will receive the following estimated revenues during fiscal year 2010 as a result of the Institute's presence in the community:

Estimated Revenues for the City, County and Other Local Taxing Districts During Fiscal Year 2010 as a Result of the Institute's Presence in the Area	
Local sales taxes to be collected by local taxing districts:	
City of Topeka and other cities in the county	$208,330
Shawnee County	$104,165
Washburn University	$135,414
Total sales tax collections	$447,909
Local transit guest taxes to be collected by the City	$190
Property taxes collected on residential property owned or occupied by direct and indirect workers:	
City of Topeka and other cities in the county	$766,036
Shawnee County	$940,306
Auburn/Washburn Unified School District 437 and other districts	$1,192,604
Topeka Transit	$70,317
Metropolitan Topeka Airport Authority	$25,549
Washburn University	$77,724
Topeka & Shawnee County Public Library	$210,928
Total property tax collections	$3,283,465
Total revenues for local taxing districts	$3,731,564

A discussion of the conduct of this analysis is next.

Conduct of this Analysis

Impact DataSource conducted this analysis using data, rates and information supplied by the Greater Topeka Chamber of Commerce and other information obtained by Impact DataSource. In addition, Impact DataSource used some estimates and assumptions.

Impact DataSource is a sixteen-year-old Austin, Texas economic consulting, research and analysis firm. The firm has conducted economic impact analyses of numerous projects in Kansas and 25 other states. In addition, the firm has developed economic impact analysis computer programs for several clients.

The firm's Principal, Jerry Walker, performed this economic impact analysis. He is an economist and has Bachelor of Science and Master of Business Administration degrees in accounting and economics from Nicholls State Institute, Thibodaux, Louisiana.

TO ALL THAT'S PRESENT:

My son, Allen Dale Jaimez is 45 years old, his height is 53" & weight is 75.4 lbs, brown eyes & brown hair. He resides at Flinthills~~—~~Midland Hills North at KNI. He has been at KNI since 07/06/1970. Lodge

I have watched my son develop & grow to his present potential with wonder & love. He was five years old when he entered KNI.

Doctors in Topeka couldn't find the correct nutrition to where Allen would tolerate & grow. Allen was very under weight & had other problems. The Professional Staff at KNI developed a plan especially for Allen which enabled him to be able to eat solid food & tolerate it, crawl, sit, stand with the help of parallel bars. He developed really fast.

Isn't it our human mission to ensure that all those with Intellectual Disabilities receive the proper care which insures that their lifestyle is at the highest potential of living? KNI exists for this purpose & has developed programs & lifestyles for each individual client to oversee all of their needs with outstanding, exceptional training for all special needs. Fragile Medical equipment & training plus the Emergency Medical Unit which save lives. This assures us as Parent/Guardians that as each sunset & sunrise occurs that we can rest assure that our Special loved ones are safe & happy.

It will be a terrible set-back for KNI to be destroyed because the State of Kansas has a budget issue. Funds that KNI use to enhance the lives of people with Intellectual Disabilities is a blessing for both the clientele & parents/guardians.

KNI is a campus which focuses all of their Special Technical Services to assist around – the- clock needs to those that reside there.

It appears your purpose is to close the doors of KNI, which will affect all those in dire needs for Special Services. I've listened to your ideas that those that resides at KNI need to be relocated into Community–Based–Housing which is supposed to save Money. This is okay only if there is ample housing available whereby those that reside at KNI will receive the same outstanding service that KNI has provided for them all these years. What is the back-up plan if the housing doesn't exist? {Ship them to a State Hospital in Parsons?} THAT'S WRONG! It will be a drastic crime if you do this to our Special Loved Ones. I firmly believe that those on feeding tubes will never fine a facility that provides all essential needs for their fragile bodies as KNI is doing at present Allen, thank God alone, isn't on a feeding tube but my heart cries for those who are.

My summation is PLEASE leave KNI open. Find ways to change, cut, consolidate & find means to make it work & don't disrupt the live of our Special Loved Ones that were given to us. Their lives have already been turned upside down by some illness that left them pleading for our guidance and expertise. Our Loved ones "Children of God" can't voice their pleas or request to the Governor or Legislature.

Thank you --Mary-Mother of a Special Person

Senate Public Health and Welfare
Date 3-2-2011
Attachment 9

WHITNEY B. DAMRON, P.A.

SUBMITTED REMARKS

TO: The Honorable Vicki Schmidt, Chair
And Members of the
Senate Committee on Public Health and Welfare

FROM: Whitney Damron
On behalf of the City of Topeka

RE: Kansas Neurological Institute (KNI)

DATE: March 2, 2011

Madam Chair Schmidt and Members of the Committee:

When Governor Brownback accepted the challenges of office on January 10, 2011 and the Legislature convened the 2011 session, no one thought the decisions needing to be made to balance the state budget would be easy.

One of those decisions under consideration is closure of the Kansas Neurological Institute (KNI) in Topeka and relocation of the residents of that facility.

I am confident you will receive testimony from a variety of sources with greater knowledge of the lives and special needs of the residents of KNI than what I can provide. However, on behalf of the City of Topeka, we felt it important to let you know of our interest, concerns and support for KNI.

KNI provides much needed services to its residents and their families that simply cannot be provided on an out-patient or in-home basis. The patients residing at KNI are generally in need of 24/7 treatment options that require an institutional setting such as that found at KNI.

While the closure of a state institution providing the kind of services as KNI might seem to make financial sense in the abstract, it is important for the state to keep in mind the fact that these patients require a substantially enhanced degree of care and service regardless of where they reside. Furthermore, changes in residency and service will be highly disruptive to the patients and their families.

The residents of KNI have some of the most profound health and life challenges imaginable and are receiving much needed services from caring professionals that would be difficult, if not impossible to replicate in another location or setting.

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Senate Public Health and Welfare
Date 3-2-2011
Attachment 10

The closure of KNI will have a profound impact upon the employees of KNI and be a significant detrimental economic impact upon our community, but more importantly, closure would be a tremendous disruption of the lives of the residents at the facility, most certainly with an impact on their quality of life, but perhaps even on their health and well-being.

One point to keep in mind when making these decisions is the fact that although the residents of KNI are living in Topeka, many have come here from other cities and counties and still have family members living throughout Kansas. The families with relatives living at KNI want the best possible care available for their loved ones and believe KNI is the appropriate venue for their care and treatment.

The impact on the lives of the residents cannot be ignored when evaluating the possible closure of KNI. Nor can the quality of life of our most dependent citizens who deserve the opportunities available to all of our citizens for appropriate health care, enhancement of life skills, community interaction and proximity to family members and loved ones.

On behalf of the City of Topeka, we respectfully urge care, compassion and caution by this Committee and the Kansas Legislature before moving forward to close a facility that has been providing critical services to the most vulnerable citizens of our community for nearly 50 years.

Our community has strong ties to KNI and the support runs deep, as evidenced by the continuing stream of supporting editorials and letters to the editor that appear frequently, written by those who have friends and family who have been served by KNI and the employees who care for them.

In closing, I have attached a copy of a new article from the *Topeka Capital-Journal* dated February 2, 2011: *Topeka Doctor questions KNI closure plan.* Dr. Lumb provides his professional insight and perspective of the issues related to closure of KNI that should be considered during your evaluation of this issue.

Thank you for your consideration of our comments and the accompanying information.

WBD

Attachment

THE TOPEKA CAPITAL-JOURNAL
cjonline.com

Published on *CJOnline.com* (http://cjonline.com)

Topeka doctor questions KNI closure plan

By Tim Carpenter
Created *Feb 2 2011 - 9:11pm*
THE CAPITAL-JOURNAL

A Stormont-Vail Health Care physician Wednesday said closure of Kansas Neurological Institute in Topeka would jeopardize health of disabled adults transferred to community housing and dramatically increase the cost of treatment for these men and women.

Gov. Sam Brownback recommended the 2011 Legislature endorse a plan to move all 156 profoundly disabled residents from KNI over a two-year period starting in July. Justification centers on dual goals of reducing state expenditures and fully embracing the community-based model of care.

Raymond Lumb has practiced medicine in Topeka for 35 years and advises Stormont-Vail staff members who provide care on KNI's campus. In an interview and a letter to the Shawnee County legislative delegation, he said implementation of Brownback's proposal would cause immediate psychological deterioration of residents and undermine their long-term physical health.

Lumb is the first medical professional to publicly question the wisdom of closing KNI.

"Even if you do this very slowly, my fear is that it will have a catastrophic impact, not only on the health and well-being of these individuals, but on their morbidity and mortality," Lumb said.

KNI's clientele require around-the-clock care because their disorders are far-reaching. Ninety-eight percent have severe or profound intellectual disabilities, 83 percent can't speak, 76 percent have seizure disorders, 68 percent are unable to walk and 33 percent receive nutrition through tubes. The median age is 47, and 94 percent have lived at KNI at least a decade.

"That's all they know," Lumb said. "The caregivers are fairly constant and stable. They have an environment that is most conducive to the stability of their mental health, their emotional health and the management of their underlying illnesses."

He said physicians accepting patients
removed from KNI won't necessarily have the benefit of observations by caregivers who can interpret nonverbal signs regarding the condition of these delicate patients.

This disconnect could lead to advancement of respiratory illnesses and other complications requiring lengthy hospitalization rather than outpatient treatment, he said.

Lumb said Stormont-Vail had 67 admissions from KNI in 2010 resulting in Medicaid reimbursement of $1.02 million. The 174 outpatient visits resulted in payment of $72,000. The hospital absorbed more than $500,000 in expenses above the Medicaid reimbursement rate.

"We felt that was part of our contribution to the community," the doctor said.

He said if 10 percent of the 156 residents at KNI were hospitalized on any given day at Stormont-Vail, the additional Medicaid cost would be $9.8 million. Expansion of the hospital's intensive-care facility to replace KNI's five-bed intensive care unit would be another $2.2 million.

"There is a clear understanding of the increase in cost and catastrophic consequence for these people," Lumb said.

Members of the Shawnee County legislative delegation were struck by Lumb's assessment.

"We have high quality of care at KNI designed over a period of years," said Rep. Joe Patton, R-Topeka. "I'm concerned they may not continue to receive that if we close KNI."

Patton said the facility's residents would have difficulty securing personal physicians in the open market.

"It's difficult to find doctors who are willing to serve individuals with Medicare," he said. "When you add to that a group of people with severe and multiple disabilities, you're going to have problems finding care."

Senate Minority Leader Anthony Hensley, D-Topeka, said the medical consequences of closure and potential cost increases would need to be factored into the Legislature's decision on KNI's future.

"The quality of life is the major issue for me," he said. "In terms of cost savings, it doesn't appear there would be much of any."

Rocky Nichols, executive director of the Disability Rights Center of Kansas, says he supports Brownback's proposal to move KNI residents out of the institutional setting. He said community services would cost less and savings should be invested in community services for developmentally disabled people.

Brownback didn't propose earmarking the savings for people with disabilities.

Closure of KNI has been an issue for several years. A state commission studied the issue, and Gov. Mark Parkinson recommended gradual reduction in residency at KNI and Parsons State Hospital allowing consolidation of programs in Parsons.

Source URL: http://cjonline.com/legislature/2011-02-02/topeka-doctor-questions-kni-closure-plan

Fw: KNI

Wed, March 2, 2011 5:25:53 AM

From: Frances Sapp <arvoniagal@yahoo.com> Add to Contacts
To: Arvoniagal@yahoo.com

I came here, today, to speak for my son, Sammy King, who lives at KNI. He doesn't have a voice box so he can't speak for himself. It was removed during a laryngetomy to separate his esophagus from his airway to prevent aspiration pnemonia. He now breathes through a trach in his neck.

Sammy was born with Downs Syndrome and Muscular Dystrophy. He stayed at home and attended grade school and high school in Emporia. His condition continued to get worse as he got older. After he graduated from high school special education, his MD had progressed to the point where we could no longer care for him at home. We looked for a community place for him then and nothing provided the care that he needed except for KNI.

Sammy now needs humified oxygen, breathing treatments 4 times a day, suctioning frequently, a giggy vest to help clear his lungs, an elevated bed, a lift to help transfer him because he only has the use of one arm and hand. He can not stand or help himself go to the bathroom. He can't brush his teeth by himself or got in bed or out of his chair by himself. He needs an emergency call light to summon help because he could be dead in five minutes if he gets a mucus plug in his airway. He needs a whirlpool bath daily to help prevent skin breakdown. He,also, needs a room, doorways, and halls big enough to drive his electric chair in.

The communtiy homes that I have visited don't have room for his electric chair which he uses to work a part-time job delivering KNI's mail around campus. They have no comparible jobs to replace the one he really enjoys. They don't have 24 hour nursing staff, the ablility to do suctioning, the humified air or oxygen that he needs at night, the giggy vest for his lungs, the emergency medical care available to him at KNI. They don't have the handicap tubs for bathing and preventing skin breakdown. Some don't even have vans with lifts for transportation. They are small, understaffed, and the staff is completely inexperienced in taking care of the kind of patients that KNI has . The community staff would be overwhelmed.

The KNI staff,who work with him on a daily have known him for years. They know how to read his lips, when he needs suctioning, when he needs a drink, when he is cold, when he is sick, when he is upset, when he has to go to the bathroom, and they know how to read the signals when he is in trouble.

If Sammy could talk, he would tell you that he is scared to death of being moved from KNI. It is his home and where he feels safe and comfortable. It is where his job is. He IS part of the community. He goes shopping, to Wal-mart, the library, the mall, to concerts, and to movies, etc. He even told the Governor, on his visit to KNI, that he wants to stay there. It's sad when someone in Sammy's shape has to beg the Governor to stay in his home.

To move Sammy and the other residents from their home, family, friends, and caring staff to unfamilar places where the staff are strangers who don't understand them, where they are understaffed, where the rooms are small and cramped compared to KNI's spacious rooms, and where they are not going to receive the same level of care is beyond cruel in my opinion.

I visit my son at KNI at least three times a week and there are clients even worse off than him. A lot more needs to be investigated before the legislature even considers these moves. They need to look at the community services and compare with KNI. They need to make sure that the money to provide services comparable to KNI's will actually follow these patients. They need to make sure that the level of care is the same as KNIs. I can tell you that right now it is not. The state will have to spend a lot of money if they are ever going to provide the same services in the community.

I read the article in the Topeka Capital Journal by the Nortonville couple who's son has been at KNI for years. They would rather have a needle put in their son's arm and have him put to sleep than have him moved from his home. Although, I don't condone their method, I certainly understand where they are coming from. It is sad to think that they would rather have their son die before he leaves KNI but, I am afraid that is what is going to happen to my son and a lot of the others soon after they are moved. Is that how the State plans to save money by the cruel deaths of the KNI residents? I sure hope that the Governor and the legislature will do the right thing and leave KNI open.

Frances Sapp
208 Chestnut
Reading, Kansas 66868

Senate Public Health and Welfare
Date 3-2-2011
Attachment 11

February 20, 2011

KNI Resident - Kevin David Allerheiligen - Age 40

Medical Diagnosis - Tuberous Sclerosis Complex. Profound physical and mental disabilities. Kevin has the typical TSC triad: mental retardation, adenoma sebaceous cysts and seizures. Individuals with TSC disease have tumors/tubers in their brain that contribute to behavioral disorders such as aggression, sudden rage, acting out, hyperactivity, obsessive-compulsive behavior, attention deficit, etc. Kevin also has an astrocytoma (brain tumor) in the left ventricle. These multiple tumors are inoperable. Tuberous Sclerosis also infiltrates and affects the nerve endings in all other major organs. Verbal skills are profoundly affected.

Governor Sam Brownback:

On behalf of Kevin's family, I wish to sincerely thank the State of Kansas for providing vital medical care and a home to my son for thirty-two of his forty years. KNI has provided a safe and caring environment that, I strongly feel, cannot be provided at any other facility. The home unit Staff on Eastwood and the on site Medical Unit Nurses have become his family, companions and irreplaceable caregivers. Kevin is totally dependent on their assistance to meet his basic physical daily needs and to oversee his ongoing chronic medical issues. They are his life line, his world.

The professional staff at KNI also know how to interface Kevin's frequent behavioral aggression. Psychotropic medication has helped, yet his combative demands can be challenging for anyone despite his weakened physical and vulnerable condition. The trained support staff are experienced using techniques to safely defuse his outbursts by attempting redirection, etc. They deserve high praise for their expertise and patience for keeping Kevin from further harming himself or harming others.

The challenges are many for my son. Since 1996 his nutritional needs became dependent on a Gastrostomy Tube. For thirty-eight years, his profound seizure activity has been treated with numerous daily medications, as well as, having a Vagal Nerve Stimulator surgically implanted. Unfortunately, these treatments have not interrupted nor stopped, in total, the intensity of his seizures. Due to the many years of seizure medications the side affects have resulted in severe bone loss....very very fragile bones...."severe osteoporosis". Due to this fragility, the drop seizures he experiences have caused numerous wounds requiring sutures; fractures such as hip, hands, arm, wrist, tibia, femur, etc. Some fractures have required surgical intervention with follow-up recovery care at KNI's medical unit. Kevin is still healing from a seizure related leg fracture from March 22, 1010. He receives in house rehabilitation.

The medical unit is a vital entity for ongoing medical needs for my son and other residents. It clearly lessens the burden on recovery hospitalizations at Stormont Vail.

My intent here is to not detail all of Kevin's medical history in my communication, as I realize how tedious that would become to the reader. My goal is to introduce you to 'part' of my son's life. A life he has had no choice but to live to the best his circumstances can allow.

Now he is facing a potential change to his life if KNI no longer exists. A potential harsh change of having to leave the security and familiarity of his home of these many years. Displacement would bring certain unneeded emotional confusion, certain emotional trauma and, possibly, a loss too great to bear. Please learn how many perished after moving into the community care in Beatrice. It is frightening.

Community homes, I feel, have inherent dangers that offer potential perpetrators a target to do harm. Whether it be of an abusive nature or assaults of any kind. Psychotropic medications, seizure medications as well as many others that are a constant requirement to sustain their medical issues, would become a target by dealers and users. In a society where social networking is used by the criminal minds as well, these homes would be vulnerable bringing about frightening life threatening situations causing overwhelming worry and concerns.

Also, law enforcement would be additionally taxed to oversee this population at many many homes as a neighborhood watch scenerio. They would then have the responsibility to investigate break ins when they occur. A nightmare.

Where are the **safety guarantees** for the people who are **defenseless**? **The answer is KNI!!!!!**

As Kevin's mother and guardian, never have I "accepted" the fact my son could not live life as you and I know it. Through no fault of our own, we've had to "learn to live with" what came our way. Mother nature brings some brutal blows to life. Some can never heal, such as TS an incurable disease. As Kevin's mother, I'll never stop grieving and I'll never cease loving my Kevin. One thing is certain, yes my son was deprived of a normal mind and a normal body, but I know within him rests a "perfect" soul.

So for the years my son has left, my ardent prayer is that he remain in his KNI home with the comforts, support and security he requires and has also become accustomed. It is vital he continue to have a "**safe haven**" which his now fragile body uniquely requires. A **community home** can never meet the intense scrutiny and medical care that KNI consistently gives. **Parsons cannot** begin to meet the demands that KNI, their medical unit and Stormont Vail Hospital consistently meet for the residents in crisis. The hospital closest to Parsons, of the same standards as SVH, is one hour away in Joplin.

I strongly feel it is a moral imperative the residents of KNI, who have to suffer silently and truly are the weakest among us, have their rights upheld. I urge you, Governor, to hear **their "NO to CLOSURE"** vote. I just know it would be unanimous.

They just want to stay **HOME**. The classic Kansas phrase - **there's no place like home.**

Thank you for your thoughtful and insightful consideration.

Judy Ford
Mother

jnjford@prodigy.net

12-2

TESTIMONY
Respectfully Submitted to the
Senate Public Health and Welfare Committee
Ann Perrin Riggs, Guardian
March 2, 2011

KNI is not an isolated place—it's a neighborhood within a larger community. KNI offers the best of any neighborhood. It's a safe, accessible place. There is safe, accessible green space to enjoy. Everyone knows their neighbor. They socialize with each other. The special characteristic of this neighborhood is that the individuals who live there need a lot of support to live a life of dignity. Over the past few years, the state has spent millions of dollars remodeling KNI, establishing this neighborhood for the neediest of the needy. It's no longer an "institution;" it's like a group of specially adapted homes—a neighborhood. KNI respects, honors, supports and celebrates each and every person who lives there.

Living in a rented house in the community doesn't mean inclusion.

The more handicapping conditions a person has, the more supports he or she needs. KNI already has these supports in place. These supports include:

- Medical supports
- Adapted wheelchairs, lifts, baths, and toilets
- Readily available vehicles, including specialized vans
- Adapted homes, walkways, and outdoor spaces
- Transportation and staff support for community inclusion
- Individualized supported employment
- Ongoing availability of adaptive equipment to facilitate supported employment, communication, and participation in everyday activities
- Ongoing physical therapy and occupational therapy support

One of KNI's most important support systems for the people who live there is consistent, well-trained staff. KNI has this. Community placements do not.

KNI's direct-care staff turnover is about 15%. The average turnover rate in the community programs is 50%. No program with a direct-care staff turnover of 50% can offer quality care. There's an organization in Lawrence with a turnover rate of 80%!

Imagine that you are totally dependent on caregivers to bathe you, change your adult diaper, or help you with using the toilet. You are dependent on these caregivers to understand your needs and wants because you can't speak, or you and difficult to understand. You are totally dependent on these car safety: do they know how to lift and position you correctly? Do the

protect you from a potentially aggressive housemate? What a nightmare if your care is provided by revolving-door staff with comparatively little training, low pay, and few benefits.

My ward, George, is shy. He gets upset when he loses a staff person. When he gets upset, his behavior problems escalate. He has limited speech, but he wouldn't be able to tell me if he was neglected by staff or abused by a housemate. That's why the supervision and accountability provided by KNI is so important.

My ward spent two years in community placement. Those two years were a nightmare for him and for me. He couldn't say, "I hate it here!" He became withdrawn and his behavior deteriorated. He began tearing up his clothes and breaking furniture. Finally, he found a behavior bad enough to show his unhappiness and anger—he started smearing feces.

When he returned to KNI, his behavior dramatically improved.

One reason why the staff at KNI are able to work with George so well: they are well trained not only in how to care for medically fragile people, but those with behavior challenges as well. During the first year of employment, KNI direct-care staff receive 310 hours of training. Compare this to the average of 54 hours of training for direct-care staff in community service systems, assuming the community staff stay around long enough to get that training. It takes well trained and consistent staff to keep those with behavioral challenges from hurting themselves and their housemates.

Please listen to us. I speak for my ward, George, and for the others who need KNI. I'm not a paid lobbyist. I don't work for an organization with a political agenda, or for a corporation.

I speak from my heart, but also with my head. KNI today is not the Winfield State Hospital of 15 years ago, and comparing the two isn't valid or helpful. Please don't let empty and self-serving assurances convince you that there are wonderful places in the community that are equal to or better than KNI. There are not.

Societies are judged by how they treat their most vulnerable. Money is tight, but life is precious. I beg you to keep KNI open.

Thank you.

"As presidents of major health care providers in the region, we understand the extremely unique and vital role that KNI plays in providing services to a special population—a special and vulnerable population that cannot be served by anyone else in the healthcare arena."

Robert Erickson
President and CEO
St. Francis Health Center

Maynard Oliverius
President and CEO
Stormont Vail Healthcare Inc.

How many people on the waiting list and in community programs want and need the services of KNI?

It is extremely difficult to get into KNI. It takes a crisis and a court order.

<u>We could lower our waiting list numbers by allowing some of those who desperately want and need KNI's services to be admitted.</u>

Things You Should Know About KNI

Please take a few moments to read the quick summary information on the following pages:

KNI's mission is to support each person who lives at KNI to have a meaningful life by:

- Ensuring well-being
- Providing opportunities for choice
- Promoting personal relationships
- Facilitating participation in the community
- Recognizing individuality

Things You Should Know About KNI

Characteristics and needs of the people who live at KNI

- All need 24-hour support and intensive support from direct support professionals
- All are adults (ages 19 to 74); 48% are over age 50; 80% are over age 40
- Median length of stay at KNI is over 30 years; 94% have lived at KNI for 10+ years
- About 90% have profound disabilities; most others have severe disabilities
- 68% are unable to walk, 83% are unable to speak. Those who can speak may have limited speech that's difficult to understand At least one individual requires staff who can sign
- 85% are incontinent or unable to use the toilet without assistance
- 76% have seizures or a history of seizures
- 33% are unable to eat by mouth; receive nutrition via tubes. 5% have tracheostomies
- 18% are prescribed psychotropic medications

- 38% require specialized behavior support services
- In 2010, over 60 admissions to acute care hospitals were necessary, as were over 75 admissions to the KNI Medical Unit
- Over 1.15 million nursing interventions were necessary in 2010
- Great need for assistive technology (personalized seating systems and other equipment)
- Over 130 people have supported employment positions (1-2 hours/week to several hours/day)

Things You Should Know About KNI

Information about the Staff at KNI

- Direct-care staff receive 310 hours training in 1st year of employment (compared to an average of 54 hours in community services system)
- All direct-care staff are trained as Certified Nurse Assistants & Certified Medication Aides (over 105 hours of training)
- Approximately 17,250 hours of training in 2010
- Turnover rate of 15% in direct support positions (compared to approximately 50% average turnover in community services system)
- Direct Support Professional average pay is $**12.76** per hour (compared to approximately **$8.75** per hour in the community services system). **Most KNI staff will <u>not</u> follow the individuals into the community if KNI were to close—they can't afford to.**
- Turnover rate of 4% in frontline supervisory positions (compared to approximately 35% average turnover in community services system)
- Physician on-call 24/7; nurses on site 24/7
- Dentist on staff

Things You Should Know About KNI

Outreach services provided by KNI

- Wheelchair clinic serving approximately 250 people per year
- Assistive Technology department serving 200-250 people per year
- Dental services to about 50-60 people per year
- Behavior support services to about 30 people per year
- Medical services to difficult to support people
- Training support through on-line training packages & on-site training
- Philosophy of meeting needs in home communities & increasing community capacity
- Partner with community agencies for Harvesters food distribution, blood drives, United Way, Project Topeka, classroom space, soccer fields, etc.

Things You Should Know About KNI

What family members and guardians feel about the services provided to their loved ones at KNI

- Transition to community services is available to all guardians
- Guardians and families are highly satisfied with the home and services provided to their loved ones
- Annual survey of guardians in 2010: Overall satisfaction with supports rated 4.75 on a scale of 1-5.
- Response averages ranged from 4.39 to 4.79
- Average response to 18 of 19 survey items was over 4.50 *(see last page)*

Things You Should Know About KNI

Why community services do not automatically provide a higher degree of community inclusion or individualization than services provided at KNI

- People at KNI live in unique homes, typically in groups of 6-8 compatible people
- People have generally shared their homes with the same group of people for many years & experience continuity, security, and friendship
- People have opportunities to establish their daily routines, opportunities for privacy, opportunities to be with family, friends and people they like
- The current population at KNI (156) contrasts with the "licensed capacity" established for a 1970s institutional model (454) and makes a vastly better quality of life possible
- KNI has been extensively remodeled to move from an institutional environment to a small-home environment
- People have frequent opportunities to participate & interact in the community (shopping, social & recreational events, employment, family contact, etc.)

- People have access to the staffing & transportation that promote access to the community
- People are employed & earn money they can spend on items and activities that

Things You Should Know About KNI

Reasons for some of the cost differences between KNI's services and services provided through the HCBS waiver for people with developmental disabilities; some of these costs will shift to other sources of governmental funding if KNI is closed.

- The cost of services at KNI includes many expenses that are not included in Home & Community Based Services rates:
- Primary medical care (Medical staff & 24/7 on-call physician)
- 24 hour on-site nursing care
- Services in KNI's Medical Unit to reduce need for ER and acute care services
- Dental services (for people living at KNI & through outreach services)
- Service coordination (Targeted Case Management)
- Transportation, including lift vehicles
- Food or nutritional formula for those who do not eat by mouth
- Customized assistive technology services (wheelchairs & assistive technology—for people living at KNI & through outreach services)

- Accessible physical environments with specialized tubs, lift equipment and other environmental modifications
- Occupational and physical therapy services, contracted speech services
- Adult disposable briefs
- Housing, utilities and maintenance
- Medication
- Services from medical specialists (optometry, podiatry, seizure clinic)
- Dietitian services, particularly for those who do not eat by mouth
- Home furnishings
- More highly trained and better paid direct support staff (Average of **$12.76**/hour at KNI vs. approximately **$8.75**/hour in community services system)
- KNI also provides State benefits such as health insurance

KNI PARENT/GUARDIAN SATISFACTION SURVEY
NOVEMBER 2010

This survey was sent to KNI parents and guardians in November 2010. The following table summarizes the response received by12/30/10 (96 surveys received)

Please answer the questions below based on your experience *during the past year.* Rate your satisfaction using this scale:

5 = Strongly agree; 4 = Agree; 3 = Neutral; 2 = Disagree; 1 = Strongly disagree; NS = Not Sure

Question	Average response (out of 5 possible)
Staff members at KNI treat the person I care about in a positive and respectful manner.	**4.79**
The home of the person I care about is clean.	**4.64**
The home of the person I care about is in good repair.	**4.65**
The person I care about is safe.	**4.68**
Staff members at KNI take reasonable steps to prevent abuse and neglect.	**4.61**
The person I care about receives good personal care from KNI's staff.	**4.73**
The person I care about has adequate time, space and opportunities for privacy.	**4.64**
Staff members at KNI do a good job of protecting confidential personal information related to the person I care about.	**4.69**
The person I care about receives support to exercise his/her rights.	**4.58**
The person I care about is treated fairly.	**4.63**
Staff members at KNI do a good job of supporting the person I care about to do the things he/she likes to do on a day-to-day basis.	**4.64**
Staff members at KNI do a good job of supporting the person I care about to experience or learn new things that are important to him/her.	**4.58**
KNI's staff provides the support necessary for my loved one to participate in the community to an acceptable degree.	**4.57**
Staff members at KNI do a good job of keeping me informed about the life of my loved one.	**4.39**
Staff members at KNI encourage me to be involved in the life of my loved one.	**4.56**
The person I care about receives the health care services he/she needs.	**4.66**
KNI's staff have been responsive to any changing needs experienced by my loved one during the past year.	**4.59**
Staff members at KNI provide the support necessary for the person I care about to identify and work toward personal goals and dreams.	**4.55**
Overall, the person I care about has received good supports from KNI's staff during the past year.	**4.73**

St. Francis Health Center
Sisters of Charity of Leavenworth Health System

Stormont-Vail HealthCare

January 27, 2011

Governor Sam Brownback
Capitol, 300 SW 10th Ave., Ste. 212S
Topeka, KS 66612-1590

Dear Governor Brownback:

We are writing this letter asking you to reconsider your decision to close the Kansas Neurological Institute (KNI). As presidents of major health care providers in the region, we understand the extremely unique and vital role that KNI plays in providing services to a special population – a special and vulnerable population that cannot be served by anyone else in the healthcare arena.

Many in the community remember the severe consequences which occurred when Kansas closed the State Hospital in 1997. This placed a huge burden on hospitals and other psychiatric facilities in the area that were not properly warned or prepared for the consequences of the closure. Many of those patients became burdens on other areas of our social and economic structure and remain so today.

This situation is even more delicate because no facility (that we are aware of) is capable of caring for this population.

There are many characteristics of the KNI population that are unique in scope and complexity that only the KNI facility is prepared to address. Some of those characteristics are as follows:

- 90% of the people who live at KNI have profound intellectual disabilities
- Three-fourths of their population have seizures or a history of seizures
- One-third are unable to eat by mouth
- 85% are unable to speak
- The average age of the residents living at KNI is 47 years and this is increasing
- The median length of stay at KNI is approximately 30 years
- Approximately 5% of KNI residents have tracheotomies requiring extensive care

Governor, thank you for your attention. While I recognize there are budget constraints, I would ask again that the KNI be removed from the closure list.

Sincerely,

Robert Erickson
President and CEO
St. Francis Health Center

Maynard Oliverius
President and CEO
Stormont-Vail HealthCare, Inc.

Cc: Representatives of the Shawnee County Congressional Delegation
Senator Stephen Morris, President of the Senate
Representative Mike O'Neal, Speaker of the House

Senate Public Health and Welfare
Date 3-2-2011
Attachment 14

Kansas Organization of State Employees
AFT, AFSCME, AFL-CIO

A New Day... A Better Way... For State Employees

Join Testimony before the
Senate Public Health and Welfare Committee
On
Closing of the Kansas Neurological Institute (KNI)
By
Jane Carter, Executive Director
August Jackson, KNI Employee
Barb Putney, KNI Employee
Karen Frost, KNI Employee
Melvin Boyd, KNI Employee
Kansas Organization of State Employees

Thank you Ms. Chairman and members of the Committee:

We are here today to support the Kansas Neurological Institute (KNI) and all it does to sustain the mental health and special needs communities of Kansas. Over 150 residents call KNI their home and we as employees and supporters of the hospital do not want to see these individuals displaced to live among strangers who cannot give them the quality care that KNI provides.

KNI provides state-of-the-art care to the immobile and the indigent residents; those who clearly cannot take care of themselves without proper assistance from trained staff. The KNI staff represented here today has taken over 300 hours of training to serve these individuals. They know firsthand how best to serve the needs of the residents entrusted to their care.

It is our opinion that the low functioning individuals have too many needs to be released into the broader community to live in group homes. Group homes will not provide the skills and expertise that KNI provides. Many low functioning individuals simply do not have the capabilities to live outside a facility setting. Many have aggressive behaviors towards other people and themselves; many have acute diseases and are disease prone while others just cannot manage without the around-the-clock treatment KNI provides.

In closing, we would like to address the economic benefits of KNI and how this institution generates vital economic development dollars for the local community. According to a study commissioned by the Topeka Chamber of Commerce[i], the total economic impact of KNI in FY 2010 was $66 million. The study also showed how KNI's revenue output and the spending of its workers support more than 1300 jobs in the area.

This institution is not only vital to the special needs and mental health communities of Kansas, but it is significant to the economic growth and stability of this state.

[i] A Report of the Economic Impact During Fiscal Year 2010 of the Kansas Neurological Institute in Topeka, Kansas. http://www.topekachamber.org/resources/PDF/58-09.KansasNeurologicalInstituteimpac

Senate Public Health and Welfare
Date 3-2-2011
Attachment 15

Please consider the safety of these vulnerable citizens and keep them in the safe community environment of KNI.

I am a guardian for a ward at KNI these words ring through my head as she described a seizure she had had. My Ward had been placed at KNI when she was 12 years old. At 21 she was placed into an established facility within the community. Fourteen years later I look back and count she has been placed in four different agencies one of them twice. Within those agencies she has had been moved 11 times.

She has had numerous emergency room visits for seizures, stitches and behaviors. She had a broken ankle but because the facility couldn't manage her therapy she was hospitalized another six weeks.

She has been admitted to Vail West four times.

Police were called numerous times; if she wasn't having seizures she was having a behavior problem.

She has been in jail at least four times, sometimes 24 hours without seizure medications causing her to seizure for days after her release. The jail called for us to bring depends to her as that is not something they stock. The personnel not understanding the mentality level told her on one occasion she was free to go. Keep in mind if this was your child, grandchild age 5/6 being left out on the street with snow on the ground no way to call anyone, confused, no coat, and cold.

She has been sexually assaulted twice, once was never reported by the facility. The most recent time her roommate was having a behavior problem the one and only staff sent my ward across the street to get help, because of her seizures she was not to cross a street by herself. Once across the street to the agencies other facility there was no staff and the ward sexually assaulted her and threatened her. This does not include the fact that she is also a product of such a crime. Staff realized she was having problems and four hours later took her to the hospital. I was not called until the afternoon of the following day. The criminal has more freedom than she does as she has suffered the consequences, the psychological trauma, along with yes more psychologists' visits and expenses, and keeping a current restraining order for her safety.

SRS was in on the documentation and still left the one facility open, and even let them hold their day programs in a bar? The house unlocked, window brok

could crawl in and the front door swinging? Staff had lied to me about her whereabouts on one occasion when I questioned them they said it wouldn't happen again. We called for a local agency to help us get her moved safely away from that home. We ended up calling a facility that had her before and got her moved to an apartment by herself with staff. Needless to say the local agency was not helpful in this situation.

Numerous times I would call and say I would be there in 20 minutes and be calling from the end of the block and find staff sitting outside or polishing their BMW in one case only the wards in the house. My ward would be showing me her latest bite marks and bruises. In one home my ward witnessed a staff person get beaten up by her ex-boyfriend, who then proceeded to drag the staff person to the other side of the apartment and continued to beat her up some more.

One of her roommates had minor surgery was sent back to the home, staff was to check on her hourly. The next morning the girl had died. My ward had numerous bites and bruises from other wards. She also had mental abuse from some of the staff. The main problem staff is never trained enough to handle the crisis situations or the day to day situations. Nor are they paid enough to keep them working. In one facility it was nothing for the staff to put in 70 hour weeks because the relief staff wouldn't show up. The wards are the ones who take the brunt of it. My ward has had numerous seizures, but one particular one in the bathroom hitting her head on the back of the stool, breaking the stool and water pouring everywhere and my ward yelling for help and no one could hear her because the other wards were making too much noise, then she would fall asleep again wake up and try to yell again. By the time staff found her the bathroom was flooded, water had run down in the shower, and soaked half of the bedroom floor.

When my ward was released from jail the last time she was placed back at KNI, there was no place else to go with her. Her medications were so far out off from different doctors, poor documentation and staff not trained enough to relay to the doctors what was going on. Now, by ward is safe from the criminal, medications again being monitored she is able to work in the office and thrift shop and do chores. Her seizures are more controlled along with her behaviors. When there is a behavior issue they are able to pull staff when they need it to assist her. Where will my Ward go if there is no KNI?

Please consider the safety for these vulnerable citizens.

Thanks – Arlene Leuszler

16-2

All these questions are answered and taken care of at KNI can you answer these questions if you close KNI?

Where are the locations of all these facilities?

Will these facilities have vehicles to transport wards to appointments?

Where do you expect to find qualified staff for all these facilities?

Is it also possible to get staff that speaks the same language to translate problems?

Where and how many doctors are you going to find in the community to treat these patients?

Will the State monitor the facilities for deficiencies?

Can you also guarantee they are not abused, or sexually assaulted?

Can regulations be put in place so when the wards leave one home their medical records go with them instead of being held hostage of the former agency and there is medical follow through?

Will they have the staff to take care of emergencies?

In case of an emergency where will you place these clients?

Can you guarantee us parents that our wards don't go to jail for lack of trained staff?

What has to happen to get a ward help in case of a behavior outbreak since the hospitals won't touch them including Vail West?

How will you guarantee that the money will follow each ward?

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
[signature]	323 SW Western Topeka 6660
[signature]	2220 SW Boswell CT Topeka, KS 6611
Thelma Hampton	2027 SE Travis Circle Topeka, Kan. 66605
Jeffery Finney	235 SW Tyler Apt #1 66603

Senate Public Health and Welfare
Date 3-2-2011
Attachment 17

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The KNI Family

Signature	Home Address
Maria Escalante	3401 SE Walnut Dr 66605
Dolores C. Adame	217 N.E. Wilson Ave.
Henry Adame	217 NE Wilson
Alicia Adame	217 NE Wilson
Lucille Escalante	125 NE Chandler
Danielle Anguish	219 NE. Wilson Av.
Juanita Adame	219 N.E Wilson Ave.
~~John Adame~~	229 SW Elmwood
Janet Adame	229 SW Elmwood
~~Alexis Padilla~~	
Matthew Guerrero	3401 SE Walnut Dr 66605

17-2

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The KNI Family

Signature	Home Address
Jose A Adame	225 SE LIME
Patricia Ortega-Adame	PO Box 750172 Topeka
Norbert Adame Jr	"
Anna DeBusk	506 NE Chester
Jeff DeBusk	506 NE Chester
Lucia Ortega	300 Sumner
Ruben Ortega	300 Sumner

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The KNI Family

Signature	Home Address
Vicki R. Simmons	2621 SE 10th Topeka, 66607
Coleen Adame	1941 NW Tyler Topeka, KS 66608
Daniel Adame	1941 NW Tyler Topeka KS 66608
SHANE M. ROBERTS	2914 SW FOXCROFT CT 1
Monika Adame	1941 NW Tyler Topeka, KS 66608
STEPHANIE STUART	2914 SW. FOXCROFT CT 1
BOB STUART	2914 SW FOXCROFT CT 1

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The KNI Family

Signature	Home Address
Kathleen Williams	1730 SW High Ave. Topeka, KS. 66604
Tanaya Stewart	1011 SE 37th Topeka, KS 66605
Starrla Johnson	2434 SE Illinois
Les Kincade	1075 W 14th Topeka, KS
Cynthia D. Price	2109 SW Harrison Topeka KS
[illegible]	1331 SW Arrowhead topeka
[illegible]	1359 Butler Rd - Meriden, KS
[illegible]	1920 SW Regency Pkwy. Apt B, Topeka
Brian T. Wooten	3825 SW Cambridge Terr
[illegible]	807 SW Frazier, Topeka KS 66606
[illegible]	3212 SW Plass, Topeka KS 66611

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The KNI Family

Signature	Home Address
Christopher Cain	2308 Jewell Topeka
Dan Lewis	2545 SW Fairmont Topeka
[illegible]	3404 Jordan Ln
[illegible]	2432 SW Mission Ave
Margaret Neville	5626 NW Rochester Rd Topeka KS
[illegible]	1900 NW Lyman Topeka KS.
[illegible]	902 Washington Horton, Ks
[illegible]	534 [illegible] KS
Toni Mishler	3762 E 117th St Carbondale KS
Benna Wilson	14515 Hwy K4 Maple Hill
[illegible]	255 N 1750 Rd Berryton, KS
Magdalena Villegas	233 NE Chandler

17-6

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The KNI Family

Signature	Home Address
	2105 SW OSBORN
	2646 NW Grand
	5420 SE, 69TH
	1153 SW Glendale Dr. Apt B
	Hoyt, KS
	Topeka, KS
	2720 SE Taurus Ct
	Topeka KS
	Scranton KS

17-7

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The KNI Family

Signature	Home Address
Bessie Crow	3515 SW 6th Ave apt 304 Topeka KS 66606
Gladys Robinson	3515 SW 6th Ave. Topeka Ks.
Maxine Miller	3515 SW 6th Ave Topeka KS
Virginia R. Studer	3515 S.W. 6th apt. 245 Topeka KS
Marjorie Morgan	3515 S.W. 6th Topeka apt 243
Sylvia Sholty	35/15 S.W. 6th Topeka KS.
Winifred H. Mason	35/15 SW 6th Topeka, KS apt 249
Theresa M. Carter	3515 SW 6th Ave apt 124 Topeka Ks 66606
Velma Scritchfield	3515 SW 6th ave apt 241 Topeka, Ks 66606
Ed Neely	3515 SW 6th Topeka, KS 66606

Petition to Save KNI!

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Signature	Home Address
Christen Heath	Top. KS 66605
Tammy Baker	3616 SE 27th Terr.
Heath Springstead	1210 NW Van Buren Topeka KS 66608
Thomas A Johnson	2824 SE Peck Rd Topeka, KS 66605
	apt # 306
	3515 SW 6th Ave Topeka Kans. 66606

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The KNI Family

turn over

Signature	Home Address
Jill A Clare	14837 Floyd Overland Park KS
Joan Seckinger	15224 W. 83rd Ter Lenexa, Ks
Jeannine Franken	1826 Perry St. #107, O.P., Ks 66204
Mary L. Rounds	3512 W. 92nd Ter. Leawood 66206
Linda C. Pascoe	4912 Mohawk Dr. [illegible] KS 66206
Rose McBratney	12761 Overland Rd, Leawood KS 66209
Arlene Kaufman	3505 W. 93rd [illegible]
Ann Hochland	9417 Delmar #112 Prairie Vlg KS 66207
Cathy Benson	8209 Tomahawk PV KS 66208
Jim C Schultz	5901 W. 107th Apt 309 OPKS 66207

(over)

17-10

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The KNI Family

Signature	Home Address
Gus Fuentes	2803 SW Volla West DR, Topeka
Jay Waring	5289 Foxridge Dr. 304, Mission
Maria Fuentes	2808 SW Volla West DR Topeka
Rosie Oberst	10730 SW Hoch RD, Auburn

17-11

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The KNI Family

Signature	Home Address
[illegible]	2000 N.W Polk Topeka, Ks. 66608
Ruth Bastian	1119 NE Forest Topeka Ks 66616
Kimberly Halseth	4145 NE HWY K4 Topeka Ks 66617
Henry Hallock Jr	4145 NE K-4 Hwy Topeka, Ks 66617
David Sons	3643 SE Virginia Topeka KS, 66605
[illegible] Martin	16408 158th Rd Mayetta, KS 66509

17-12

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The KNI Family

Signature	Home Address
[signature]	6827 SW Windsong Dr 66619
[signature]	6813 SW Crestwood Dr 66619
[signature]	1726 SW Harrison 66612
Ed Passmore	4138 SE Ridgeview Terr. Topeka, Ks
[signature]	949 SE Long St Topeka KS 66607

17-13

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The KNI Family

Signature	Home Address
Cheryl Smith	300 NW Grant ST #304
[illegible]	305 SW Taylor
Kay Kuna	927 NE Freeman
Lori Miller	1206 NW Hwy 24 & 40 + 51
Andrea Jackson	1510 SW Lane 15A
HARRY VAUGHN LANE	220 NE 59th TOPEKA
FRED CANHAM	312 KANSA OZAWKIE
Leelan Barrow Lane	220 NE 59th ST. Topeka
James Zabel	220 NE 59th St Topeka
[illegible]	2710 NE Division Topeka Ks.
Chris Kauffman	" " " " "

17-14

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The KNI Family

Signature	Home Address
Kristeen Frost	
Jessica Frost	3431 SW Gage blvd #8
Karen Frost	4129 SW Emland
Adin Ai	212 Throop Apt 1
Donny J. Sanders	1121 SW Boswell, Ave
Heidi Steines	
Dale & Kris Putney	305 NW mensa Lane, Topeka
Brian L. Gaden	200 NW Redbud Circle, Topeka
Barb Putney	
Wayne C. Christensen	3559 SW Edge Road, Topeka KS
Antoinette M. Jones	3105 S.W. Atwood, Topeka, KS

17-15

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The KNI Family

Signature	Home Address
Susan Wilson	2400 SW Seabrook Ave.
Rochelle T Kinson	202 SE 40th Terrace
Marilyn McGuire	19430 Harley Stilwell
Karla Gassen	1724 NW 33rd Pl, Topeka

17-16

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Signature	Home Address
Daryl L. Johnson	3101 SW Randolph Apt D
Ken Daniel	5630 SW Fairlawn
Audrey [illegible]	3330 SW Eveningside Dr #20
[illegible]	2200 SW [illegible]
Mary Anne Cewartz	708 NE Chester
Victor Cewartz	708 NE Chester
Paul Holtman	3611 SW Watson CT
Brenda Marsh	3838 SW Cambridge Ct

17-17

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The KNI Family

Signature	Home Address
Marilyn White	3615 S.W. 38th Terr Topeka, KS 66610
Patricia Robbins	5008 SW 17th Ter. Topeka, KS 66604
Stanley D. Murphy	3912 SW Atwood Terr. - Topeka, KS
Ronda S Galloway	4205 SW Stone Ave Topeka, KS 66610
Bill Gelly	4205 SW STONE AVE Topeka, KS 66610
Doug Johnson	3512 NW Rochester Topeka 66617
C M Neil	3210 Muirfield Topeka 66618
Sara Reese	633 HIGHLAND AVE TOPEKA, KS 6607
Dawn Bailey	1914 SW Arnold Topeka KS 66604
	7210 SW Fountaindale RD 66614

17-18

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Linda Duncan	814 Ash St Lyndon, Ks 66451
Mrs Kimberly D Reed	2609 SW Seabrook
Keivn McChristian	636 SE Golden
LaTisha Duffy	2805 SW. Fairway Dr
Jana Kerschner	4233 SW Emland Dr 5th
Mindy Stark	1321 SW Burnett Rd.
Holly Maxwell	2744 SW. Villa West Dr. Apt 201
Josefina A Gonzalez	910 SW tyler ST.
Maria Melendez	436 Ne Sumner.
Maria Torres	400 SW Buchanan
Angelika L Smith	6741 SW Fairdale

17-19

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Gail A Bobst	8891 222nd Rd Holton, KS 66436
	3400 SW James St Topeka KS 66614
	19582 13th St Lawrence Ks 66047
	Topeka KS
	1714 SW Lane Topeka KS
	3431 SW Gage
	3611 a Atwood ~~Gage~~ Apt B KS
	3568 SW Mission Ave. Topeka 66614
	3550 SW Randolph Topeka Ks 66611
	4342 SW 30th Terr 66614
	4434 SW Golly Creek Dr 66610

17-20

Petition to Save KNI!

Please HELP!!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
	4832 SW Commanche Rd.
Patricia Montgomery	3408 SW Burnett Rd Apt B
Phillip Montgomery	4841 SW 17th St #2
	4621 SW Gage Blvd
	4621 SW Gage Blvd
Taylor J. Wilson	4621 SW GAGE Blvd.
Dustin Bouton	8751 Park South Ct #206
DUSTIN Ross	1521 SW 23rd St.
	7233 Kentucky
	3528 SE 10th

17-21

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
	1634 SW Mulvane
	6135 SW 26th Ct
	4434 SW Colly Creek Dr. Topeka
	3304 SW Skyline Pkwy
	3385 S Fremont
	3401 SW Gage apt E
	828 NE Oakland

17-22

Petition to Save KNI!

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The KNI Family

Signature	Home Address
	3715 SW Mourdview Ct
Molly Griffin	3715 SW Mourdview Ct
Robert Hovey	4604 SW Mulligan Dr
Sean Newman	1610 S.W. Lane
Kyle Smith	500 SW Vanburen
	1634 SW 22nd Topeka KS
Victor Carter	2920 SW Gage Apt 121
	828 NE Crocker
	3720 SW 34th St.
	4134 SW 6th St #214
Haley Finn	3347A SW Burlingame

17-23

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Theron Tacott	1265 Lane 66604
Kim Kaylor	1265 SW LANE
Shadra Munsell	1265 SW Lane
[illegible]	3620 SW Plass Ave Apt D
[illegible]	
Ryan Leroy Bell	

17-24

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Norman Vaten	11269 Hadley St OP KS 66210
Charlene Mullen	16144 Lenexa, OP KS 66085
Mary Jo Singleton	5187 Q. 75 St. PV KS 66208
Barbara Hedel	13249 Delmar Ct Leawood, KS 66209
Cynthia M. Zittlosa	3500 W. 128th ST, Leawood, KS 66209
John F. Nyhoff	14750 S. Mullen Olathe, Ks 6606
Cory Parker	596 Twin Brook, Lee's Summit, MO 64081
Barbara Higgins	12329 Walnut, OP, KS 66209
RJ Mertz	11500 Granada LN Leawood KS 66211
Linda McGeorge	12887 Cambridge Cr. Leawood 66209
Shawn M. Allen	10107 W. 98th St. OP, KS 66212

17-25

Petition to Save KNI!

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The KNI Family

Signature	Home Address
[signature]	9521 W. 116th St Overland Park, KS 66210
[signature]	5348 W 150th Ter Leawood, KS 66224
Lori Leibrandt	8801 Birch Prairie Village, KS 66207
Judy Gleason	9109 E El Monte Prairie Village, KS 66207
Dan Sipes	9327 Overlook Dr Overland Park, KS 66207
Dawnee Maurer	12521 Nieman Rd Overland Park KS 66213
Kay Payne	9823 Juniper O.P. KS 66207

17-26

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Billy D. McGuire	1943 S Hardy, Lot 2, Topeka 085
Marcell Moore	17500 W 119th St #206 Olathe KS 66061
Bill & Rita Wilt	8509 W. 79th St O.P. KS 66204
Pam Wheeler	14714 Hawthorne Wichita, KS
Tricia Wheeler	" " "
Jay W. Ford	12810 Oakmont Dr, Platte City, MO
DEAN LIPPOLD	8903 W. 127TH TERR, OVERLAND PARK 66213

17-27

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Joyce DeMaranville	18721 Linwood Rd. Linwood 66052 Ks.
Carol L. Hubbel	2820 N. 156th st. Basehor, Ks 66007

17-28

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Jolene Dougherty	14361 SW 190th St Rose Hill, Ks 67133
Harold Johnson	2322 Cimarron Rd Galva Ks - 620-345-8558
Robert Zeller	4414 SE WISCONSIN TOPEKA, KS
Tom Allen	TOPEKA, KS 66609
Carla Golden	4118 SW 33RD TERR TOPEKA, KS 66614
Barbara Taylor	6624 SW 10th Top. Ks. 66615
John Lee	5221 SW 23rd ST Topeka KS 66614
Kent Caleb	3431 SE. Ohio Ave. Topeka, KS. 666
Timothy Baker	2323 S.E. Cuvier st. Tecumseh, Ks 66542
	1771 SE 29th Terr Top. KS 66605

17-29

Petition to Save KNI!

"Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Carolyn Pantle	2824 N 156th St Basehor KS 66007
Marilyn McBallew	15614 Hollingsworth Rd. Basehor, KS 66007
Chyleen Pavesich	3219 N. 110 St. Kansas City, KS 66109
Charlene Kain	16481 149th Ct Bonner Springs KS 66012
Roberta Schmitz	1320 So 105th St Edwardsville, Ks 66111
Jennifer Young	16319 Stoneridge Dr. Basehor, KS 66007
Jerrell Young	15319 Stoneridge Dr. Basehor, KS 66007
Billie J. Jacobson	22948-155th St. Leavenworth, KS 66048
Jane Greenwood	3933 N. 125th St. Kansas City, KS 66109
Norma J. Palmer	16431 - Linwood Rd. Bonner Spgs - Ks 66012

17-30

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital.
Please sign the petition to save KNI now!

Signature	Home Address
Jason Boyd	4438 SE Truman Ave Topka, Ks 66609
Warren J Bayer	323 Denison St Manhattan Kans 66502
Jo Ann Bayer	323 Denison Manhattan, KS. 66502 Ph. 785-539-8447
Lee Kilburn	15424 Roger Rd LV 66048
Jack Baker	16627 174 st Bonner
[illegible]	1662 South 130th Bonner Springs 66012
Kenneth W Buschow	24140 W 55th St. Shawnee Ks 66226

17-31

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Joyce De Maranville	18721 Linwood Rd. Linwood Ks 66052
Carol L. Hubbel	2320 N. 156th st. Basehor, Ks 66007

17-32

Signatures	Address (Home)
Bee Tuttle	5109 W. 111th Ter., Leawood, KS 66211
Nancy Baker	4209 W. 92nd Terr PV, Ks 66207
Marta Padula	6600 Wenonga Lane WHKS 66208
Pat Cline	9308 Cherokee Pl. 66206
Madeleine Klein	47 Lakeshore Dr. 66032.

Petition to Save KNI!

overnor Sam Brownback released his budget and proposed the closing of KNI. This move ill put our special-needs community in poor positions as well as disrupt their treatment. Over 50 residents call KNI their home and the city of Topeka as well as the state of Kansas rely n its economic benefits. We can't let them close the hospital. Please sign the petition to save NI now!

The KNI Family

Signature	Home Address
Sarah Miller	740 NE Arter
Travis Richie	740 NE ARTER
Brian Bellew	5231 SW 34th
Pam Tremblay	6124 NW Jennings Rd
Keith Tremblay	6124 NW Jennings Rd
Carol Noriega	2140 Auburn Rd
Jose Noriga	2140 Auburn Rd
Andrea Reed	2349 SW Westport Dr. Topeka KS 66614

17-34

Please help save Kansas Neurological Institute

The clients at KNI have lived there for 20,30,40 or more years they deserve to Stay in the only home they know. The staff get training on how to treat the clients and how to handle they if they become angry. The staff at KNI have become like family to the clients and the families of the clients. The clients and their families deserve some peace in knowing they are being taken care of by honest, trustworthy people. The clients get to live a quality life at KNI and they are treated as a person not an inconvenience. Politicians should not get to make these important decisions that affect our community as a whole. Lets stand together and show governor Brownback that we support each other in our community and we are not going to let him make decisions for us. If KNI closes 150 people or so will be out of a job how does this help our economy?

Please show your support and sign today

Thank you

Frankie [illegible]

[illegible]

Isaac [illegible]

[illegible]

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Betsy Wysaik	4213 SW Misty Harbor Ave
	Lawrence KS
	Topeka KS
Mark Doerr	2321 SW Romar Rd
	1904 SW Fairbourn Rd.
Lee Ann Townsley	3200 SW Eveningside Dr. Apt 9
Evelyn Conway	1922 NW Horne Ave
Megan Moore	5201 SW 34th Topeka, KS
Tracy Gassman	Topeka Ks. 66614
	4436
	Limbaugh

17-36

Petition to Save KNI!

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The KNI Family

Signature	Home Address
	1310 School St. Auburn KS
	3718 SW KIOWA ST. TOPEKA KS 66610
	3200 SW Evenings Dr. Topeka KS 66604
	4851 SW Commerce, Topeka, KS 66604
	3602 SW Woodstalley Ct Topeka 66614
	7272 SW Stonehaven.
	4042 SW. 36th
	3133 SW Twilight
	4606 SW Mountview Dr
	3924 SW 40th St Topeka KS 66610

97-37

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Tammy KMG Kin	3625 S WESTBARKE
[illegible]	3861 SW Atwood Ave
Jill Schoendaller	8861 SW Atwood Ave
Diane Holdren	700 NW Walnut
Diana Bair	1715 SW Meadow Ln
Brandy Johnson	4806 SW 36th Terr
Terri Florenco-Williford	3101 Wisconsin.
Michael Dowd	2654 ARROWHEAD DR # B
Tamara Duff	945 N. Porter Ave Wichita Ks
Robert L. Miller	4806 SW Cochise Ct
Paul Jones	200 NE Lake St Ulo 16

17-38

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Riley Swan	5281 SW 31st Apt. 90e
Cathy Jean King	4201 SW 23rd St.
Brenda Roberts	3340 SW Skyline Pkwy.
[illegible]	4213 SW MISTY HARBOR AVE TOPEKA
Brent Byford	3317 S.W. 37th
Kristopher Miller	4801 SW Cochise Ave Tpks 66614
Jessica Mendez	3200 SW Eveningside #4
Adrian Potter	3424 SW Burnett
Randy Wheat	722 SE Soldier
[illegible]	4523 SW CRENSHAW
Ashley Sullivan	3330 Eveningside dr.

17-39

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Jeannie Blackwell	1621 N.E. Quincy
Cindy Holt	3717 SW Mission Ave
Walter Cox	3208 SW Evening Side DR
Mark Heath	1414 SW BYRON #2
[illegible]	5221 SW Kent Pl.
[illegible]	3763 SW Woodvalley Dr
Jean Ann Emig	4827 SW Comanche Rd
Cam Bass	
[illegible]	3924 SW 39th St Topeka
Adam Rathe	3208 SW Eveningside Dr.
Sherita Dean	3504 S.W. Skyline Pkwy

19-40

Petition to Save KNI!

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The KNI Family

Signature	Home Address
	720 SE 37th St.
	2527 Hudson
	3761 SE Fremont
	138 S.W. Gage.
	4418 SW 34th
	3320 S.W. Evergreen Dr.
	3313 SW. 37th St.
	3434 SW 47th Pl. - Topeka
	3635 SW Evergreen Dr Topeka
	5229 SW 23RD St
	2912 SW Indian Tr. Topeka

17-41

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Randall R. [illegible]	2819 SW 31ST CT
Pam Slack	3908 SW 40th St. Topeka
Cyndra Sieges	3608 Eveningside Topeka
Mary F Sanders	426 Rice Road
[illegible]	1206 SW MACVICAR
[illegible]	1904 SW 66th
[illegible]	City
[illegible]	3708 SW 34th St
Christine [illegible]	4227 SW 33rd Terr.
Jerad [illegible]	3301 SW Eveningside dr
Taylor Moore	3301 SW Eveningside dr

17-42

Petition to Save KNI!

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The KNI Family

Signature	Home Address
[illegible]	2031 SE D Topeka KS 66607
[illegible]	2944 SW. Wayne Tpke 66611
Kenneth Posey	6604 SE Rice Rd
[illegible]	4083 SE Truman Ave Topeka 66609
[illegible]	1239 SE Madison
Jeff Jenn	235 SW Tyler 66603
Daniel Chege	629 SE Quincy Street
[illegible]	3320 SW 47th Ct. 66610
[illegible]	2139 SE Virginia Ave 66605
[illegible]	1023 SE Lawrence
[illegible]	909 SE 23rd

17-43

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Kim Barnett	2300 SE Madison St.
Lucy Fair	2331 SW Burnett Rd
Katrina Jones	1018 SW Boswell
[illegible]	1512 SW HARRISON
[illegible]	P.O. Box 8876 (08)
[illegible]	1603 SW 72 Pl Topeka KS 66619
[illegible]	1300 S.E. Illinois
[illegible]	1603 SW 72nd Place 66619
Sarah Mays	3423 SW Sena Dr Topeka
Rex Stevens	3423 SW Sena Dr Topeka
[illegible]	2821 Monroe

17-44

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Monroe Griffith	4003 SW Barons Topeka Ks
Leo Ruiker sr.	2624 SE Gilmore ct.
Agnes Clark	822 SE Overton St.
Barry Collins	1328 SE 19th ST
Alicia M. N	4208 SE Oakwood St 66609
Allison English	3726 SW Twilight Dr 66614
Ellis English	3726 SW Twilight DR 66614
Royce C. Bailey	2837 SW. Prairie Rd #21 Topeka, KS 666
Clarence Hall	2038 SE [illegible] Topeka KS
Carmen Webster	4918 SE Kentucky Ct 07

17-45

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Alberta Roche	2108 Wyandotte Olathe 66062
Kathleen P. Bartels	8 Holly Dr, Olathe, KS 66062
Rose Madden	14178 W 151 Terrace Olathe KS 66062
Marilyn Dutt	9514 Redbud Lenexa, KS 66220
Joan Donnelly	1807 S. Parkwood Dr
Cindy Gillaspy	1324 E. 152nd Terr. Olathe, KS 66062
Phyllis Vithoulkas	11565 So. Ballentoz, Olathe, KS
M. L. Rummel	1118 W. Wabash Terr. Olathe KS 66061
Marilyn OBrien	1510 Lakestone Dr Olathe KS 66061
Sharon Ward	14490 Hunter Dr, Olathe, KS 66061

17-46

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Barbara J Warner	14533 W. 139th
Sue Eisenlau	2383 W. Elizabeth Olathe, Ks 660
Marla Hulse	11537 Penrose Olathe KS
Lois Phillips	11565 S. ~~[illegible]~~ Bell Court Dr. #103 Olathe Ks
K. Swenson	14246 W. 122nd TR OLATHE KS 66062
Judy Reichmann	3509 W 92 Pl Leawood Ks 66
Wm J Walsh	13249 Delmar Ct. Leawood Ks.
Jack Reichmann	3509 W. 92 PL, Leawood, KS

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Richard Ogen	
Jack W. Lowry	8900 Delmar P.V. KS
James R. Graham	13810 Metcalf #12319 O.P. KS 66223
Marlene Graham	13810 Metcalf Ave. #12319 O.P. KS 66223
John H Henke	3502 W. 92 Pl 66206
Sam Kellerman	3404 W. 92nd Terr. Leawood, K. 66206
Becky Marlin	4117 W. 94th Terr P.V. KS 66207
George Higgins	4800 W. 96th St OPKs 66207
Adele Korte	9732 State Line S.M KS 66206
T. Dayhoff	2209 W 104 Leawood KS 66206
J M Rakowsky	11221 Granada Leawood 66211

17-48

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Kathleen M Bailey	13718 Woodward Overland Park, Ks 66223
K Bailey	13718 Woodward Overland Pk., Ks. 66223
Richard Johnson	3505 W 93rd St Leawood Ks 66206
Maxine B. Schlichter	2312 West 103 Terrace Leawood Ks 66206
Joan Rogerson	5612 W. 92nd St OPKS 66207
Ray J. Simmons	9401 Mission Rd Leawood KS 66206
Mary Anne Henke	3502 W. 92nd Pl. Leawood, Ks. 66206
Jack A Henke	9531 Reel, O.P. Ks. 66207
Mary Ann Henke	9531 Reel, O.P. Ks 66207
John + Ann Wiseman	8873 ROSEWOOD DR PV KS 66207

17-49

Petition to Save KNI!

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Signature	Home Address
Joan John	512 Northrup Ave.
Marsha L. Delantar	10400 Caenen Dr. OP KS 66215
Kimberly Klem	12865 Cambridge Terr. Leawood 66209
Josephine C. Nigro	3440 W. 129 Ter. Leawood KS.
Shawn Whitten	8106 Acuff Lane, Lenexa, Ks
Wendy R. Oakley	8203 W. 127th A OP KS.
Maureen Neu	9591 Outlook OP KS
Sonia Rueda	9116 Roe Ave., P.V. KS 66207
Chris Gile	8310 W. 127th Pl. OP, KS 66213
Katie Reper	7621 Marty OP KS 66204

17-50

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Jack Lowry	8900 W. 93rd St.
Catherine H. Lowry	
Joan Wessman	8878 Ridgewood TV 66207
Nancy Kuckelman	12767 Overbrook Rd Leawood KS 66209
Nancy A. Kellerman	3404 W. 92 Ter Leawood, Ks 66206
Kristy S. Kuckelman	"
Williams Johnson	8425 CHEROKEE LN. LEXINGTON KS 66209
Mary M. Nagle	10005 Juniper Ln OP 66206
Robert E. Smith	5831 W. 87th Ter OP, KS 66207
Susan M Hagan	16613 W 146 Terr Olathe, KS 66062

17-51

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Betty J. Edwards	9300 Mohawk Lane
Bill Edwards	9300 Mohawk Lane
Ed Regan	10160 Mackey O.P. KS
Madelyn Regan	10160 Mackey OP KS
Erin Krueger	8908 W. 92nd Terr OP KS
David Horn	8343 Lakewood Ave Lenexa KS
Shelby Liberty	6513 W 106th OP KS
Shelby Liberty	6513 W. 106th OP, KS
Sara Nunes	5201 W. 98th Terr. OP, KS 6620
Lisa Ledom	8845 Mission Rd. Leawood KS
Marjorie Livingston	12309 KNOX O.P. KS. 66213

17-52

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
[illegible] E. Virginia	5916 W. 98th St., OPKS
Jack Nagl	10005 Juniper OPKS 66207
Mary Lou Catron	9625 GRANADA OKS 66207
Mary E. Maider	3831 W 95th Terr. Leawood KS 66206
Kimberly L. Farrell	7517 W. 102nd St. Overland Park, KS 66212
Sister Julie Galan	9403 Mission Rd. Leawood, KS 66206
Ann Morris	2304 W. 104th St. Leawood, KS 66206
Bridget Cegan	17616 W 70th St Shawnee, KS 66217
Dee Jablonski	9111 W 76th Terr. OPKS 66204
Lisa Waters	10414 Alhambra, OPKS 6620[illegible]

17-53

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Kit Everly	12310 W 119th Place apt 418 Overland Park, KS. 66213
Ann Schwesmann	10460 S. Mockingbird Ln Olathe Ks 66061
Sandy Deegan	11815 S. Clare Rd. Olathe KS 66061
[illegible]	[illegible] W. 140 Ter OP Ks 66224
Desiree Miller	14075 W 215 Bucyrus, KS 66013
Edna Cameron	13030 Quivira Rd O.P KS 66213
Christena Higgins	2033 S Stagecoach Olathe Ks 66062
Mary J. O'Brien	1413 N Annie Olathe 66061
[illegible]	PO Box 445 Carbondale, KS 66414
[illegible]	106 SW Clay Topeka KS 66606
Jolene Green	1808 SE John St Topeka, KS 66605

17-54

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

Signature	Home Address
[illegible]	3812 SE 32nd st
[illegible]	3550 SW Randolph
[illegible]	3500 SW 29TH TOPEKA
[illegible]	3870 SW Mission Ave,
[illegible]	3439 SW [illegible] St
[illegible]	4132 SW 6TH AVE Topeka. KS. 66606
[illegible]	3713 S.W. 37th St, 66614
Patricia K. Rocha	1168 NW The Drive 66606
Matt Madison	4443 SE Pean Ave
[illegible]	3842 SW Cambridge
[illegible]	1724 SW 27th St.

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Alison PreKopy	3732 White Lake Plaza Dr APT 106
Denise Sanders	1617 SE 38th Terrace 66609
Ronda Ellis	3941 E. 165th Overbrook, KS 66524
Rusty McDonald	9421 NW 42 Silver Lake
Danny Howard	2819 SW Dukeno's Rd Topeka
Barbara Horn	2200 S.W. Kenilworth Ct. 66606
Aaron McDonald	4127 SE Ridgeview Terr 66610
Lynn Woodruff	1806 S.W. 42 Topeka 66609
Todd Mikel Adelson	1800 S.W. 42 Topeka 66609

17-56

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Phyllis Nunnery	7202 SW Timerwood Dr T.K
Dawn Hunter	11310 SW Tomill Rd
Angie Minnis	3770 Park Dr.
Lisa Bowers	389 Main
[illegible]	2407 SW Roman Rd.
Geri Blankenship	4420 SW 61st St
Vicky Cervantes	3223 S. W. Twilight
[illegible]	1125 SW 31st
Sam [illegible]	2612 SE Minnesota Ave.
Jim Hawkins	3730 S.W. park Apt #1
Kassiah Martin	637 SW Wayne Ave

17-57

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Debbi Walter	105 Elm St 2 of 2 Overbrook 66524
[illegible]	410 milton Herbert, KS 66402
Mia Mulky	711 S.W. Plass Ave 66606
Leona Sawyer	3637 SE 6th Topeka KS 66607
[illegible]	712 NE Forest Topeka KS 66616
Michelle Patton	313 Nichols St Scranton KS 66537
[illegible]	2620 SW Morningside Rd. Topeka, Ks. 66609
Kim Watson	2330 SW Eveningside Dr Top, KS 66614
Becky Chambers	15698 SE Indian Valley Ln, Hoyt KS 66440
Cheryl Davenport	17-58

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Courtney Davis	1148 SW Macvicar Topeka
Miranda Adkins	312 Fowler, Maple Hill
Stephanie Shelby	1738 NW Countryside RD Topeka, KS
C DeVader	13975 Hy K16 Holton
Kaylee Taul	116 NW Redbud Cir #7 Topeka
Linda Hannigan	2225 SW. Hazelton Ct. Topeka 66604
Debra Johnson	1336 Overlook dr Apt 10 Topeka 66615
Rita Cross	1420 SW Burnett Topeka Ks 66604
Adrienne Boyd	2916 SW Hillcrest Rd Topeka KS 666
Jos MDOE	2060 NW GAGE TOPEKA KS 66608

17-59

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
	2319 SE Monroe
	3321 Se 38th St.
	3521 SW 34th #25
	1919 Adams #25
	1170 SE Golden Ave
	3405 NW Dandy Dr.
	2725 NE Springcreek
	908 SE 44th Terrace
	3020 E Wisconsin
	3348 SE Girard

17-60

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Jocelyn Joiner	2524 SE Virginia Topeka, KS 66605
	4607 SW 29th St Topeka KS 6661
Ralph H. MacDonald	3200 SW Evenrysde DR Topeka KS 66614
Lynda Raikes	3500 SW 29th #120
Janice Perez	3915 NW 38th Terr Topeka KS KS
Mabel Leonard	5229 SW West Topeka
Doug Wilkinson	2608 SW Hillcrest Rd Topeka KS
Jesse Wood	119 NW Taylor Apt 1 Topeka, KS
Louis Ketter	3926 SW 39th Ter, Topeka, KS
Bob E Smith	1611 SW 33rd Topeka 66611
	400 SW 27th St. Topeka, Ks. 66611

17-61

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Wilson F. Ingram	3539 SW Kiowa St TPK
Gretha D. Ingram	3539 SW Kiowa St TPK
Avon Pepper	2955 McClure rd
Frederick Callahan	3600 Gage Blvd #95
Clara Chavira	3535 SW Eveningside Dr.
Tom Schwan DVM	3437 SW Arrowhead Rd
Dale Zeb (Please)	4836 SW Cochise
Donald Hutchings	342W SW ARROWHEAD RD
Kathy Zeckser	4018 SW 39th St Topeka
	3708 SW34 Topeka KS 66614

17-62

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
	4125 Misty Harbor
	5648 SW Fairlawn Rd Topeka
	3118 SW 35th Terr
	602 SE Ridgeview Dr
	4420 SW 34th Apt 13
	34th Street
	3927 SW Cambridge Terr 66610
	3728 SW James
	2126 SE 21st ST.
	3570 SW Mission
	960 N Milton

17-63

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Ursula E Spielmann	3600 S. W. Gage
Brenda Reese	3431 SW Gage #16
Cory Thomas	3541 SW NEPARKE CT
Rene Anguiano	3334 SE Colorado
Cathy Crawford	3128 SW 34th St
[illegible]	1837 SW 36th St.
Kristin Kohn	240 SE Michigan Ave
Ashley Herr	3925 SW 39th St.
Marcus Moore	3654 SW Oak Pkwy
Dean Brouhard	4420 SW 34 Th ST
Tim A Lox	2638 SW ATWOOD TERR.

17-64

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
	3320 SW Eveningside Dr. #11
	817 SW Tyler #2 66612
	420 north st. Lawrence, Ks 66044
	13520 SW 81st Auburn, Ks
	3420 SW Mourdview Cr. Topeka
	3401 SW Mission Ave 66614
	3501 SW 37th St 66614
	3413 SW Arrowhead Rd 66614
	3425 SW Twilight Dr. 66614
	5142 SW Burlingame 66609
	5142 SW Burlingame 66609

17-65

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Peggy Leis	3704 SW 29
Pam Heitkotter	819 SW High
Bill Morley	3600 SW Gage #35
[illegible]	3934 SW 40 TER
Ruth Nelson	3934 SW 40 Terr.
[illegible]	3200 SW Eveningside Dr
Jesse Berrick	220 SE 46th Street
Elizabeth Root	4545 SW Elevation Ln
Robert Rancher	460 NE 30th Cir
Veronica Marrufo	1613 SW 37th Terr. #1102

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Keith A. Cochran	346 NE 62nd St Topeka, Ks
Denise L. Cochran	" " "
Ellen Wards	1117B S.W Glendale Dr Topeka Ks
[illegible]	3321 NE Happy Hollow T, KS
[illegible]	3321 N E Happy Hollow
Susan Runyan	Po Box 37. Silver Lake, KS
[illegible]	4420 NW Hoch Rd. P.O Box 37 Silverlake KS
[illegible]	3908 N.W. Topeka Blvd #3 Topeka KS
[illegible]	2412 SE SHOREWOOD CT. TOPEKA KS 66605
[illegible]	4010 SW 43rd St, TOPEKA, KS 66610
[illegible]	4010 SW 43rd St, Topeka KS 66610

17-67

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Myra Varner	3278 31st St Grantville, KS
Jake Woodward	4804 NW FIELDING PL #2 TOPEKA, KS 66618
Sarah Long	3907 NE 30th Ter. Topeka KS 66605
Art Mills	5225 NE Birchwood Dr Topeka KS 66617
Joel D Stubbs	4243 N.E. Croco Rd Topeka Ks 66617
Duncan	5847 SW 28th Terrace Topeka KS 666
Crystal Brock	5847 SW 28th Terrace Topeka KS 6661
Dawn	5225 NE BIRCHWOOD DR TOPEKA. KS 66617
Kathleen Brown	3331 SE Arbor Topeka 66605
Randy Brown	" " "

17-68

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Tony Ford	
Darin Wright	1806 SW 33 To. KS.
Lawrence A. Wright	" "
Cindi McFarland	1819 NW Tyler
Margie Eklund	1168 SW Mifflin Ct.
Lynn Ford	545 NE 62nd St
Jay Bond	1525 NW 35th
Dan P. Jergen	2450 NE 39th Topeka, Ks
Mark Boswell	5037 NW Dawdy Topeka, KS.
Wanda Rinvogel	3626 NE Crocord Topeka Ks

17-69

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Billy J. Shelton	5018 NW Kendall Dr, Top, KS 66618
Kelli D Munsell	1607 nw 82nd 66618
Becky Gruber	2220 nw 62nd 66618
Nichole H Seitter	2925 NE Happy Hollow Blvd
Diane Malloy	415 NW Union Dr. Top KS 6660
Ash Ring	1747 SW Webster Ave Top, KS 666
Bob & Donna Cosgrove	2683 N.E. 39th Topeka, KS.
Mike Dempenny	2450 NE 39th Topeka, KS 66617
Tami Deghand	887 NE Green St. Topeka, KS 666

17-70

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Anita Monday	1320 N.W. Logan St., Topeka 66608
Clifford E Cussey	601 N.W. BROAD ST, TOPEKA KS 66608
Kathy Hall	3906 NW Topeka Blvd #2, 66617
Audrey McKinley	
Mike McKinley	

17-71

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Mary Weston	510 N.W. 35th Topeka Ks
Kim Zeller	2775 NE 39th Topeka, KS
Kenny Weston	510 N.W. 35th Topeka, Ks
Wanda Weston	4932 NE Indian creek rd Topeka Ks.

17-72

Petition to Save KNI!

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The KNI Family

Signature	Home Address
R. D. Cogswell	4727 N.W. Kendall Dr. Topeka, KS 6661

17-73

Linda Woods 2821 SE Monroe

Kristy Percell 3906 SE 33rd Terr City 66605

Sherri L Kelly 2325 SW Briarwood Plz #305-E Topeka KS (11)

Jolene Harris Topeka KS. 66614

Monique Fortune 2932 SE Illinois Ave Topeka KS 66605

David Hysten Jr 727 SW Vesper

Nikki Burnett 3524 Twilight Dr Apt 209

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Dr. Kenny Rucks	19450 Hardy Stilwell KS 66085
[illegible]	5229 Crest Drive Ks 66106
[illegible]	PO Box 281, Stilwell KS 66085
Betty Jones	5402 W 103 Terr O.P. Ks 66207
Linda Dent	1448 E Meadowlane, Olathe KS 66062
R L White	5405 W 145th TERR OP KANSAS 6622
Ralph Broadrick	28005 New Lancaster Louisburg, KS 6602
Mary Jo Broadrick	28005 new Lancaster Louisburg KS
Dorothy Ulrich	13816 Lowell - OP KS
Patricia Coyle	11316 Hemlock - O.P. KS 66210

17-75

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital.
Please sign the petition to save KNI now!

Signature	Home Address
Norma J. Canady	15897 W. 157th St. Olathe 66062
Jack C. Canady	15897 W. 157th St. Olathe 66062
[illegible]	15514 Floyd St., OP, KS 66223
Norma J. Hinkle	6814 W. 138th Terr Apt 816 O.P. Ks. 66223
Elli Schoene	1801 E. 155th St. Olathe, KS 66062
Josie Beeler	6552 N. Parker Ter. Olathe KS 66061
Elaine Harris	Johnson Cty. Aff. 3739 Overland, Kan
Doris M. White	5405 W. 145th Ter - Leawood KS. 66224
Barbara L. Johnson	10229 Long Seneca, KS 66215
Nancy Hanrahan	10001 W. 156 O.P. KS. 66221
Wilma Mulley	5429 W. 145th Ter, Leawood KS 66224
Charles R. Glenn	11200 W. 191st St. Spring Hill, KS. 66083

17-76

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Sheran Peery	2349 SW WESTPORT DR. 66614
Jessica Peery	1084 SW Lincoln
Brandon Humphreys	" "
Sarah Michael	833 SW Watson Ave
Justin Michael	" "
Kelly Bayless	911 Hedgewood Ave
Jason Bayless	" "
Rodges Michael	SE 45th street
Ashley Wellman	5231 SW 34th
Alycia Noriega	6124 NW Jennings Rd

17-77

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Debra Howland	3430 SW Lakeside DR. 66614
Merrilee Buchmeier	2014 SW. McAlister Ave
Nichole Buchmeier	
[illegible] Taylor	207 S.E Lakewood Ct 66609
[illegible]	1120 SW 16th

17-78

Petition to Save KNI!

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The KNI Family

Signature	Home Address
	10117 W. 96th Lenexa KS 66214
	12825 Briar Dr. Lenwood KS 66209
	506. S Vine St Lansburg KS 66053
	10905 S. Applewood Ln, Olathe, KS 66061
	8030 Glenwood St. O.P. KS 66204
	4867 W 159 TH TER STILWELL KS 66085
	3304 W 91st St Leawood KS 66206
	7904 Juniper Dr. Prairie Village KS 66208
	10714 W. 96th PL O.P., KS 66214
	10714 W. 96th PL O.P. KS 66214

17-79

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Robert C. Tippitt	3409 W. 92 St. Leawood, Ks. 66206
Robert D Hashagen	21624 W 71 Ter Shawnee, KS 66218
Michael E Hunter	14205 S Kantree Dr Olathe, KS 66062
Paul A. Cubotta	801 W 97 St O.P. KS 66212
Norma J. Lippold	3409 W. 92nd St. Leawood 66206
Sherry A Schuster	10912 Cottonwood, Lenexa, Ks. 66215
Marilyn Johnson	5601 Barton Ln. Shawnee, KS 66203
Linda Stewart	14629 Brentwood, Lenexa, KS 66215
Char Byrne	7700 W 148th St, OP, KS 66223
B Rockwell	11741 Cody St OP KS 66210
Lisa Shrum	7614 monrovia lenexa. KS 66214

17-80

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Marge Dunnaster	6425 W. 145th Street, O.P., KS
Virginia Dean	100 W. 108th Ct. K.C. Mo.
Mary Duncan	12704 Cedar Leawood, KS
Nan Zemla	12208 Farley Overland Park KS
Virginia Olson	9528 Rosewood - OPKS
Paula Joyce	7809 W 117th Ter OP
Arlene DaSilva	20411 Rafferty RD PH MO 64080

17-81

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Carlene Bernard	5811 Summit, Shawnee, KS 66216
Mary C. Rees	12821 Cedar Leawood, KS 66209
Linda Marler	4714 Antioch, Merriam Ks. 66203
Joy Jones	22 Country Ct P.V. KS 66208
Barbara J. Brown	Kingswood Manor
Dana Sheb Syne	5102 W 96 Terrace
Kelly Breslin	13020 Linden St.
M. Cross	8312 W 119th Ter. O.P. Ks
Lillian Lindsey	10909 W. 96th Ter. OP KS 66214
JOYCE DEHAEMERS	9322 PAWNEE LN. LEAWOOD 66206
Judith O'Connor	9107 W. 129th St., OPKS 66213

17-82

Petition to Save KNI!

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Signature	Home Address
Karen Smith	2913 SW 36th St.
Barb Entrikin	3304 SW 29th Terrace #3
[illegible]	1933 SE Washington Topeka KS 66607
[illegible]	3734 Sandy Humboldt
Mary Meier	
[illegible]	4210 SE 21st Topeka KS 66607
[illegible]	1745 Green Acres
Shirley A. Smith	
[illegible]	801 SW 57th LOT A12
[illegible]	Dillwanty

17-83

Petition to Save KNI!

Governor Sam Brownback released his budget and proposed the closing of KNI. This move will put our special-needs community in poor positions as well as disrupt their treatment. Over 150 residents call KNI their home and the city of Topeka as well as the state of Kansas rely on its economic benefits. We can't let them close the hospital. Please sign the petition to save KNI now!

The KNI Family

Signature	Home Address
Renie Lang	5852 SW Candletree Dr. Apt. #5
Danielle Schultz	3813 SE Truman
[illegible]	3813 SE Truman
Margaret Jones	5231 SW 34th St apt 2L
Maria Woods	KNI
Jamie Gill	3401 SW Burnett Apt D
Brent Kahle	KNI

17-84

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Terry Konrad	4021 SE 61st Berryton Ks 6641
[illegible]	560 Washington ~~Topeka~~ Auburn, Ks
Pat Adams	2812 SW Hillcrest Rd Topeka Ks 6661
[illegible] Williams	1917 SW Lincoln Topeka KS 666[illegible]
Marilyn Downing	4439 SE Truman Ave Topeka Kansas
Bruce Alexander	1707 SE 24th Topeka, Kansas 66605
Delores Schlodder — Adam's grandma. These are loved ones. Don't put them through this 785-364-2640	807 W. 2nd. Holton, Ks 66436
Mary Schlodder	1002 Kansas Holton, Ks 66436
[illegible]	510 SW Fillmore TOPEKA, KS 66606
Cathy L Thomas	2417 Bellview Apt B TOPEKA KS 66605
Lenora Banks	2139 SE Virginia

17-85

Petition to Save KNI!

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The KNI Family

Signature	Home Address
	4404 SE Stone Ledge Dr. Topeka
Larry D. White	645 SE Golden Topeka 66607
Vixette Lewis	2031 SE Travis Ct Topeka, Ks 66605
Cheryl Swopes	3440 SE 23rd Terr. Topeka, KS
	1920 SE 37 Topeka, KS
Ernest Luster	1730 WASHBURN Topeka, KS
Kelly Fulton	2409 SE Monroe
Vera L. Steele Jr.	2324 SE Gemini Ave
Andrea M Quarterman	832 SE Brookside Dr.
Lisa D Tuck	1500 SE 43RD ST
Nikita Kemp	2727 SE Golden Ave.

17-86

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Cody D. Hill	642 Goldenbelt blvd - Junction City 66441
Joe Swopes	3440 SE 23rd Terr.
Carol Lockhart	
Theo Lockhart	
August W Jackson III	305 SW Taylor
Wenna Charles	912 SE 21st.
[illegible]	2641 SE Virginia
Rochelle Tolliver	208 SE 40th Terrace
Kendra White	605 Se golden ave Topeka
Dwayne L. Miller	5213 SW 31st Terr. Topeka, KS 66614
Cindy Davis	1935 SW Fillmore, Topeka, KS 66

17-87

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Pamela Bond	1901 SE Indiana Ave.
[illegible]	3625 SE Ness Ave
[illegible]	" " " "
Evan Watson	2744 SW Villa West Dr 151
[illegible]	901 SE 36th Terr Topeka KS
Kenneth Price	3434 S.W. Clove AVE
[illegible]	2111 SW Hocker Rd
[illegible]	2901 SE Kentucky Ave
[illegible]	4214 SE [illegible]
[illegible]	206 S SE 14th Street
[illegible]	720 SE Carnahan

17-88

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Veronica Byrd	2022 SE Turnpike Ave 66605
Antonio Talbert	2709 SE Munroe Topeka, Ks 66605
Bradley Lee	2107 SE 6th Ave Topeka, ks 66605
William F. Hopper	924 S/E 37th St. Topeka Ks. 66605
Robert Kennedy	2130 SW Brookfield St Topeka, 66611
Randy Cole	700 S Carnahan Ave. Topeka 66606
Belinda Bruce-Austin	3477 SW Mapp Ave Topeka
Mickey Combs	3510 SW Skyline Pkwy Topeka Ks
Antonio M. Thorn	3506 SE Shawnee Ct. Topeka, KS 66605
Angelique D. Norwood	2333 ~~3611~~ SE Bellview Apt E Topeka KS 66605
Yvonne A Jones	3611 SE Powell Topeka KS 66605

17-89

Petition to Save KNI!

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The KNI Family

Signature	Home Address
	36a SE Humboldt
	3740 SW Park South Ct
Linda Goodwin	2821 SE Colorado Ave
Lynn Proby	520 SE 26th
	5811 W Candletree DR Apt 4
	1320 27th
	5741 SW 22nd Terrace, #5
	2230 SW Hazelton CT Topeka KS 66614
	3340 NW 43rd ST Topeka 666
Robyn Hunter	6034 SW Grandview, Topeka 66606
	2403 Danbury Place Lawrence KS 6604

17-90

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Brenda Johnson	2718 S. E. Golden
Maryan Wingo	2901 Kentucky
Charity Hueldyn	3563 SW Kiowa
	3563 SW Kiowa
	1037 SW Garfield Apt 4 66604
	1645 SW 37th Terr.
Jo Hodson	1022 S.W. Webster Ave.
	1520 SW College Ave.
Carla Brown	6712 SW Swonthold Rd.
La'Trashia Redding	6712 SW Swonthold Rd.
	3542 SE Humboldt St 66605

17-91

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Anica Jones	3111 SW Twilight Ct 66614
Louis J. Tillay	1604 SE 38th TERR.
Louis E. Pillay	414 SE [redacted] Lake St. 66607
Tracey R Wilson	2823 S.E Colorado Ave 66605
Melodine Byrd	1324 SW 13th 66604
[illegible]	2115 SW 29th St
[illegible]	3325 SE Madison 66605 1/2
Tanya James	1707 S.E. 29th Terr 66605
Sara Wallace	726 S.W. Mifflin Rd 66606
Virgil E Byrd	2228 S.E. Monroe 66605

17-92

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The KNI Family

Signature	Home Address
Renee Bryant	3756 SE Fremont st Topeka
Reed Cop	1844 SW Pembroke Tpk
Robin Riddel	808 Market Osage City KS
Ben Alyost	785-580-9896
Tiffany Cody	5010 Congressional Way 66049
Robyn Lallert	2709 SE Monroe 66605
Runnessa L. Williams	1179 SW Garfield
Jamie Manry	2028 SE Massachusetts #C KS
Dave Henderson	2810 SE Highland Ct
Pete Nelson	3319 SE Kellam
[illegible]	4051 SE Truman Ave.

17-93

Petition to Save KNI!

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The KNI Family

Signature	Home Address
Edna Coyle	323 SW Western Ave
Pam Renovato	130 8 24th Street
[illegible]	900 N. Kansas Ave
Kathy Duncan	77 SW Peppertree Lane; 66611
[illegible]	~~[illegible]~~ SW 701 SW Tpk 66603
Patricia Kavalchuk	1535 SW Jewell Ave.
Bobbi Orton	[illegible] Minnesota
Nemetta Caldwell	705 SW buchanan
[illegible]	2501 SE Ohio 66605
Renee Richardson	5512 SW 19th. Topeka 66604

17-94

Petition to Save KNI!

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The KNI Family

Signature	Home Address
[signature]	1140 SW Collins Ave
L. Suzanne Anderson	3637 SE 6th St. H-4
Amy D. Strong	5519 SW 15th Terr. Topeka KS 666604
[signature]	727 S.E. Golden Ave.

17-95