educational mission and identify anticipated benefits to the university, its students, and the WSU community (i.e. applied learning, joint research, faculty start-up, WSU curriculum or program support, etc.), and must agree to the essential ground lease terms and restrictive covenants. Interested tenants will be evaluated on: proposal terms, demonstrated benefit to WSU, design concepts, financial stability, and proposed use. Rental rate shall be assessed per leased or leasable square foot of the building but is negotiable based on term of lease and benefit to the university. The university will consider serious offers and inquiries with detailed proposal terms from any financially qualified individual, group, organization, or company and such offers will be considered until a selection is made or this notice is withdrawn. If interested, please contact Vice President for Research and Technology Transfer, Dr. John Tomblin, john.tomblin@wichita.edu or University Property Manager Crystal Stegeman, crystal.stegeman@wichita.edu. This publication is being published pursuant to K.S.A. 75-430a(d), to the extent applicable.

Crystal Stegeman
University Property Manager
Office of the Vice President for
Finance and Administration
Wichita State University

Doc. No. 046978

State of Kansas

Department for Aging and Disability Services
Department of Health and Environment Division of Health Care Finance

Notice of Proposed Nursing Facility Medicaid Rates for State Fiscal Year 2020; Methodology for Calculating Proposed Rates, and Rate Justifications; Request for Written Comments; Notice of Intent to Amend the Medicaid State Plan

Under the Medicaid program, 42 U.S.C. 1396 et seq., the State of Kansas pays nursing facilities, nursing facilities for mental health, and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The Secretary of Aging and Disability Services administers the nursing facility program, which includes hospital long-term care units, and the nursing facility for mental health program. The Secretary acts on behalf of the Kansas Department of Health and Environment Division of Health Care Finance (DHCF), the single state Medicaid agency.

As required by 42 U.S.C. 1396a(a)(13), as amended by Section 4711 of the Balanced Budget Act of 1997, P.L. No. 105-33, 101 Stat. 251, 507-08 (August 5, 1997), the Secretary of the Kansas Department for Aging and Disability Services (KDADS) is publishing the proposed Medicaid per diem rates for Medicaid-certified nursing facilities for State Fiscal Year 2020, the methodology underlying the establishment of the proposed nursing facility rates, and the justifications for those proposed rates. KDADS and DHCF are also providing notice of the state's intent to submit amendments to the Medicaid State Plan to the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) on or before September 30, 2019.

I. Methodology Used to Calculate Medicaid Per Diem Rates for Nursing Facilities.

In general, the state uses a prospective, cost-based, facility-specific rate-setting methodology to calculate nursing facility Medicaid per diem rates, including the rates listed in this notice. The state's rate-setting methodology is contained primarily in the following described documents and authorities and in the exhibits, attachments, regulations, or other authorities referenced in them:

A. The following portions of the Kansas Medicaid State Plan maintained by DHCF are being revised:

1. Attachment 4.19D, Part I, Subpart C, Exhibit C-1, inclusive;

The text of the portions of the Medicaid State Plan identified above in section IA.1, but not the documents, authorities and the materials incorporated therein by reference, is reprinted in this notice. The Medicaid State Plan provisions set out in this notice appears in the version which the state currently intends to submit to CMS on or before September 30, 2019. The Medicaid State Plan amendment that the state ultimately submits to CMS may differ from the version contained in this notice.

Copies of the documents and authorities containing the state's rate-setting methodology are available upon written request. A request for copies will be treated as a request for public records under the Kansas Open Records Act, K.S.A. 45-215 et seq. The state may charge a fee for copies, in accordance with Executive Order 18-05. Written requests for copies should be sent to:

Secretary of Aging and Disability Services
New England Building, Second Floor
503 South Kansas Avenue
Topeka, KS 66603-3404
Fax Number: 785-296-0767

A.1 Attachment 4.19D, Part I, Subpart C, Exhibit C-1: Methods and Standards for Establishing Payment Rates for Nursing Facilities

Under the Medicaid program, the State of Kansas pays nursing facilities (NF), nursing facilities for mental health (NFMH), and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility reimbursement formula is divided into 11 sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Rate Adjustment, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, and Retroactive Rate Adjustments.

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 129-10-17. It organizes the commonly incurred business expenses of

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providers into three reimbursable cost centers (operating, indirect health care, and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease, and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports:

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 129-10-17.

When a non-arms length or related party change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an ongoing operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in K.A.R. 129-10-17.

2) Rate Determination

Rates for Existing Nursing Facilities:

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2016, 2017, and 2018.

If the current provider has not submitted a calendar year report during the base cost data period, the cost data submitted by the previous provider for that same period will be used as the base cost data. Once the provider completes their first 24 months in the program, their first calendar year cost report will become the provider's base cost data.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in K.A.R. 129-10-18.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per diem cost, each year's cost data is adjusted from the midpoint of that year to November 30, 2019. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility should be considered in determining the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and per diems to cover costs not included in the cost report data. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. The rate components are explained in separate subparts of Attachment 4.19D of the State Plan. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities (New Enrollment Status):

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to November 30, 2019. This adjustment will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index (IHS Index). The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to November 30, 2019. The provider shall remain in new enrollment status until the base data period is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

Rates for Facilities Recognized as a Change of Provider (Change of Provider Status):

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2016-2018. If base cost data is not

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available, the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider.

All data used to set rates for facilities recognized as a change-of-provider shall be adjusted to November 30, 2019. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to November 30, 2019. The provider shall remain in change-of-provider status until the base data period is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status):

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding the base cost data period.

All cost data used to set rates for facilities reentering the program shall be adjusted to November 30, 2019. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to November 30, 2019. The provider shall remain in reenrollment status until the base data period is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in reenrollment status.

3) Quarterly Case Mix Index Calculation

Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.20, 34 group, index maximizer model is used as the resident classification system to determine all case mix indices, using data from the MDS submitted by each facility. Standard Version 5.20 (Set D01) case mix indices developed by the Centers for Medicare and Medicaid Services (CMS) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents, including those receiving hospice services, where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

Rates will be adjusted for case mix twice annually using case mix data from the two quarters preceding the rate effective date. The case mix averages used for the rate adjustments will be the simple average of the case mix averages for each quarter. The resident listing cut-off for calculating the average CMIs for each quarter will be the first day of the quarter. The following are the dates for the resident listings and the rate periods in which the average Medicaid CMIs will be used in the semi-annual rate-setting process.

Rate Effective Date:	Cut-Off Dates for Quarterly CMI:
July 1	January 1 and April 1
January 1	July 1 and October 1

The resident listings will be distributed to providers prior to the dates the semi-annual case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database.

4) Resident Days

Facilities with 60 beds or less:

For facilities with 60 beds or less, the allowable historic per diem costs for all cost centers are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish

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the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule for facilities with more than 60 beds. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to November 30, 2019. The inflation will be based on the IHS Global Insight, CMS Nursing Home without Capital Market Basket index.

The IHS Global Insight, IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2018 historic cost reports in the database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non-owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15-bed or less facility. The per diem limit for a 15-bed or less facility is inflated based on the State of Kansas annual cost of living allowance for classified employees for the rate period. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an admin-

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istrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit:

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit is 105% of the median determined from a total resident day-weighted array of the property fees in effect April 1, 2019.

Cost Center Upper Payment Limits:

Schedule B is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care, and Direct Health Care. The schedule includes a per diem determined from the base cost data from all active nursing facility providers. Projected cost reports are excluded when calculating the limit.

The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy for facilities over 60 beds. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to November 30, 2019. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the I IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index.

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

The final results of Schedule B are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	130% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of the quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four decimal places, of the facility cost report period case mix indices for all Medicaid facilities.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

The first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the statewide average CMI for the cost report year by the facility's cost report period CMI, then multiplying this answer by the facility's inflated costs. This step is repeated for each cost report year for which data is included in the base cost data.

The second step is to determine per diem costs and array them to determine the median. The per diem cost is determined by dividing the total of each provider's inflated case mix adjusted base direct health care costs by the total days provided during the base cost data period. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are eight million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $80 and the upper payment limit is based on 130% of the median, then the upper payment limit for the statewide average CMI would be $104 (**D**=130% x $80).

7) Quarterly Case Mix Rate Adjustment

The allowance for the Direct Health Care cost component will be based on the average Medicaid CMI in the facility. The first step in calculating the allowance is to determine the Allowable Direct Health Care Per Diem Cost. This is the lesser of the facility's per diem cost from the base cost data period or the Direct Health Care upper payment limit. Because the direct health care costs were previously adjusted for the statewide average CMI, the Allowable Direct Health Care Per Diem Cost corresponds to the statewide average CMI.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The facility's Medicaid CMI is determined by averaging the facility average Medicaid CMI from the two quarters preceding the rate effective date. The facility's Medicaid CMI is then divided by the statewide average CMI for the cost data period. Finally, this result, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated semi-annually to account for changes in the Medicaid CMI. To illustrate this calculation, take the following situation: The facility's direct health care per diem cost is $80.00, the Di-

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rect Health Care per diem limit is $104.00, and these are both tied to a statewide average CMI of 1.000, and the facility's current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $80.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the result by the Allowable Direct Health Care Cost. In this case that would result in $72.00 (0.9000/1.0000 x $80.00). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next semi-annual adjustment rose to 1.1000, the Medicaid Acuity Adjustment would be $88.00 (1.1000/1.0000 x $80.00). Again the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

8) Real and Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original property fee was comprised of two components, a property allowance and a property value factor. The differentiation of the fee into these components was eliminated effective July 1, 2002. At that time each facility's fee was re-established based on the sum of the property allowance and value factor. The providers receive the lower of the inflated property fee or the upper payment limit.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated to 12/31/08 and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the Kansas Medical Assistance program for the first time is explained in greater detail in K.A.R. 129-10-25.

There is a provision for changing the property fee. This is for rebasing when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in K.A.R. 129-10-25. The rebased property fee is subject to the upper payment limit.

9) Incentive Factors

An incentive factor will be awarded to both NF and NF-MH providers that meet certain outcome measures criteria. The criteria for NF and NF-MH providers will be determined separately based on arrays of outcome measures for each provider group.

Nursing Facility Quality and Efficiency Incentive Factor:

The Nursing Facility Incentive Factor is a per diem amount determined by four per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $3.00 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.50 per diem add-on. Providers that achieve a staff retention rate at or above the 75th percentile will earn a $2.50 per diem add-on as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a staff retention rate lower than the 75th percentile but that increase their staff retention rate by 10% or more will receive a per diem add-on of $0.50 as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a Medicaid occupancy percentage of 65% or more will receive a $0.75 per diem add-on. Finally, providers that maintain quality measures at or above the 75th percentile will earn a $1.25 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

The table below summarizes the incentive factor outcomes and per diem add-ons:

Incentive Outcome	Incentive Add-Ons
CMI adjusted staffing ratio ≥ 75th percentile (5.18), or CMI adjusted staffing < 75th percentile but improved ≥ 10%	$3.00 $0.50
Staff retention rate ≥ 75th percentile, 72% Contracted labor < 10% of total direct health care labor costs or Staff retention rate < 75th percentile but increased >= 10% Contracted labor < 10% of total direct health care labor costs	$2.50 $0.50
Medicaid occupancy ≥ 65%	$0.75
Quality Measures ≥ 75th percentile (640)	$1.25
Total Incentive Add-on Available	**$7.50**

The Culture Change/Person-Centered Care Incentive Program:

The Culture Change/Person-Centered Care Incentive Program (PEAK 2.0) includes six different incentive levels to recognize homes that are either pursuing culture change, have made major achievements in the pursuit of culture change, have met minimum competencies in person-centered care, have sustained person-centered care, or are mentoring others in person-centered care.

Each incentive level has a specific pay-for-performance incentive per diem attached to it that homes can earn by meeting defined outcomes. The first three levels (Level 0 – Level 2) are intended to encourage quality improvement for homes that have not yet met the minimum competency requirements for a person-centered care home. Homes can earn the Level 1 and Level 2 incentives simultaneously as they progress toward the minimum competency level.

Level 3 recognizes those homes that have attained a minimum level of core competency in person-centered care. Level 4 and Level 5 are reserved for those homes that have demonstrated sustained person-centered care for multiple years and have gone on to mentor other homes in their pursuit of person-centered care. The table below provides a brief overview of each of the levels.

Level and Per Diem Incentive	Summary of Required Nursing Home Action	Incentive Duration
Level 0 The Foundation $0.50	Home completes the KCCI evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and workbook. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for reapplication.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 1 Pursuit of Culture Change $0.50	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels 1 and 2 in the same year. Homes that do not achieve Level 2 with three consecutive years of participation at Level 1 may return to a Level 0 or sit out for two years depending on KDADS and KSU's recommendation.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 2 Culture Change Achievement $1.00	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes may start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.
Level 3 Person-Centered Care Home $2.00	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
Level 4 Sustained Person-Centered Care Home $2.50	Homes earn person-centered care home award two consecutive years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.
Level 5 Person-Centered Care Mentor Home $3.00	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from nursing facilities. Nursing Facilities for Mental Health serve people who often do not need the NF level of care on a long-term basis. There is a desire to provide incentive for NFMHs to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to seven dollars and fifty cents. It is designed to encourage quality care, efficiency and cooperation with discharge planning. The incentive factor is determined by five outcome measures: case mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. Each provider is awarded points based on their outcomes measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case mix adjusted staffing ratio equals or exceeds 3.88, which is 120% of the statewide NFMH median of 3.23. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.55, which is 110% of the statewide NFMH median. Providers with staffing ratios below 110% of the NFMH median will receive no points for this incentive measure.

NFMH providers may earn one point for low occupancy outcomes measures. If they have total occupancy less than 90% they will earn one point.

NFMH providers may earn one point for low operating expense outcomes measures. They will earn one point if the per diem operating expenses are below $26.56, or 90% of the statewide median of $29.51.

NFMH providers may earn up to two points for the turnover rate outcomes measure. Providers with direct health care staff turnover equal to or below 42%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover greater than 42% but equal to

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or below 55%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for the retention rate outcomes measure. Providers with staff retention rates at or above 84%, the 75th percentile statewide will earn two points. Providers with staff retention rates below 84% but at or above 60%, the 50th percentile statewide, will earn one point.

The table below summarizes the incentive factor outcomes and points:

Quality/Efficiency Outcome	Incentive Points
CMI adjusted staffing ratio ≥ 120% (3.88)of NF-MH median (3.23), or CMI adjusted staffing ratio between 110% (3.55) and 120%	2, or 1
Total occupancy ≤ 90%	1
Operating expenses < $26.56, 90% of NF-MH median, $29.51	1
Staff turnover rate ≤ 75th percentile, 42% Staff turnover rate ≤ 50th percentile, 55% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention ≥ 75th percentile, 84% Staff retention ≥ 50th percentile, 60%	2, or 1
Total Incentive Points Available	8

Schedule E is an array containing the incentive points awarded to each NFMH provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

The survey and certification performance of each NF and NFMH provider will be reviewed quarterly to determine each provider's eligibility for incentive factor payments. In order to qualify for an incentive factor payment a home must not have received any health care survey deficiency of scope and severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that correct the "G" level deficiencies within 30 days of the survey, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will be eligible to receive 100% of the calculated incentive factor. The survey and certification review period will be the 12-month period ending one quarter prior to the incentive eligibility review date. The following table lists the incentive eligibility review dates and corresponding review period end dates.

Incentive Eligibility Effective Date:	Review Period End Date:
July 1	March 31st
October 1	June 30th
January 1	September 30th
April 1	December 31st

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 129-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment, or field audit adjustment.

11) Retroactive Rate Adjustments

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

II. Medicaid Per Diem Rates for Kansas Nursing Facilities

A. Cost Center Limitations: The state proposes the following cost center limitations which are used in setting rates effective July 1, 2019.

Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	$40.11
Indirect Health Care	115% of the Median Cost	$54.40
Direct Health Care	130% of the Median Cost	$129.48
Real and Personal Property Fee	105% of the Median Fee	$10.01

These amounts were determined according to the "Reimbursement Limitations" section. The Direct Healthcare Limit is calculated based on a CMI of 1.0314, which is the statewide average.

B. Case Mix Index: These proposed rates are based upon each nursing facility's Medicaid CMI calculated as the average of the quarterly Medicaid CMI averages with cut-off dates of January 1, 2019 and April 1, 2019. The CMI calculations use the Kansas Medicaid/Medikan CMI Table. In Section II.C below, each nursing facility's Medicaid average CMI is listed beside its per diem rate.

C. Rates: The following list includes the calculated Medicaid rate for each nursing facility provider currently enrolled in the Medicaid program and the Medicaid case mix index used to determine each rate.

Facility Name	City	Daily Rate	Medicaid CMI
Village Manor	Abilene	195.56	0.8944
Alma Manor	Alma	178.29	0.9294
Life Care Center of Andover	Andover	161.06	1.0502
Victoria Falls SNF	Andover	179.61	0.9710
Anthony Community Care Center	Anthony	172.41	0.9956
Medicalodges Health Care Center Arkansas City	Arkansas City	180.91	0.9745
Arkansas City Presbyterian Manor	Arkansas City	194.04	0.9921
Arma Operator, LLC	Arma	175.41	1.2234
Medicalodges Atchison	Atchison	206.36	1.0145
Atchison Senior Village	Atchison	211.10	0.9061
Dooley Center	Atchison	211.31	0.7553
Attica Long Term Care	Attica	207.01	0.8554
Good Samaritan Society-Atwood	Atwood	214.57	0.9796
Lake Point Nursing Center	Augusta	164.60	0.9079
Baldwin Healthcare and Rehab Center	Baldwin City	206.84	1.2300
Quaker Hill Manor	Baxter Springs	177.23	1.0173

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Facility Name	City	Daily Rate	Medicaid CMI
Catholic Care Center, Inc.	Bel Aire	229.64	1.1046
Belleville Healthcare Center	Belleville	160.21	0.9730
Mitchell County Hospital LTCU	Beloit	240.66	1.1051
Hilltop Lodge Nursing Home	Beloit	194.66	1.0365
Bonner Springs Nursing and Rehabilitation	Bonner Springs	180.90	1.0838
Hill Top House	Bucklin	207.44	0.8640
Buhler Sunshine Home, Inc.	Buhler	212.24	0.8885
Life Care Center of Burlington	Burlington	177.77	1.1522
Eastridge Nursing Home	Centralia	239.63	1.0134
Heritage Health Care Center	Chanute	172.00	1.0194
Diversicare of Chanute	Chanute	172.18	1.1554
Chapman Valley Manor	Chapman	184.54	0.9710
Cheney Golden Age Home Inc.	Cheney	184.77	0.9728
Cherryvale Care Center	Cherryvale	167.81	1.0695
Chetopa Manor	Chetopa	169.28	0.9274
The Shepherd's Center	Cimarron	204.87	0.9182
Medicalodges Clay Center	Clay Center	212.45	0.9643
Clay Center Presbyterian Manor	Clay Center	204.43	1.0669
Clearwater Nursing and Rehabilitation	Clearwater	194.05	1.0807
Park Villa Nursing Home	Clyde	174.08	0.9485
Coffeyville Regional Medical Center	Coffeyville	275.11	1.2800
Windsor Place	Coffeyville	190.64	1.0640
Medicalodges Coffeyville	Coffeyville	221.20	1.0952
Windsor Place at Iola, LLC	Coffeyville	183.01	0.8445
Colby Operator, LLC	Colby	191.29	1.2812
Prairie Senior Living Complex	Colby	220.98	0.8877
Pioneer Lodge	Coldwater	168.92	0.7915
Medicalodges Columbus	Columbus	213.23	1.1189
Mt. Joseph Senior Village, LLC	Concordia	184.90	1.0868
Sunset Home, Inc.	Concordia	193.29	0.9746
Spring View Manor	Conway Springs	181.19	0.9559
Chase County Care and Rehab Center	Cottonwood Falls	223.19	1.1413
Diversicare of Council Grove	Council Grove	165.59	1.0690
Hilltop Manor Nursing Center	Cunningham	175.24	1.0811
Westview of Derby	Derby	131.09	0.9490
Derby Health and Rehabilitation	Derby	210.99	1.0473
Hillside Village	DeSoto	191.84	0.9878
Trinity Manor	Dodge City	185.56	1.0310
Sunporch of Dodge City	Dodge City	207.98	0.9359
Manor of the Plains	Dodge City	214.43	1.0980
Medicalodges Douglass	Douglass	193.07	0.9752
Downs Care and Rehab Center, LLC	Downs	193.49	1.1091
Country Care Home	Easton	175.99	0.9932
Parkway Care and Rehab Center, LLC	Edwardsville	199.14	1.0737
Kaw River Care and Rehab Center, LLC	Edwardsville	229.41	1.0959
Edwardsville Care and Rehab Center	Edwardsville	166.29	0.7209
Lakepoint Nursing Center-El Dorado	El Dorado	175.11	0.9825
El Dorado Care and Rehab Center, LLC	El Dorado	214.93	1.1061
Morton Co Senior Living Community	Elkhart	187.20	1.0154
Woodhaven Care Center	Ellinwood	199.25	0.9646
Good Samaritan Society-Ellis	Ellis	187.12	1.0218
Good Sam Society-Ellsworth Village	Ellsworth	190.48	1.0419
Emporia Presbyterian Manor	Emporia	215.54	1.1336
Holiday Resort	Emporia	166.35	1.0118
Flint Hills Care Center, Inc.	Emporia	147.51	1.0290
Enterprise Estates Nursing Center, I	Enterprise	185.43	1.1336
Eskridge Care and Rehab Center, LLC	Eskridge	164.75	0.8285
Medicalodges Eudora	Eudora	175.67	0.9332
Eureka Nursing Center	Eureka	181.88	0.9929
Kansas Soldiers' Home	Fort Dodge	204.23	0.8440
Medicalodges Fort Scott	Fort Scott	182.64	1.0370
Fowler Residential Care	Fowler	226.68	0.9240
Frankfort Community Care Home, Inc.	Frankfort	182.75	0.9347
Medicalodges Frontenac	Frontenac	170.11	0.9488
Galena Nursing Home	Galena	180.62	1.1011
Garden Valley Retirement Village	Garden City	170.61	0.9821
Homestead Health and Rehab	Garden City	184.22	0.9289
Ranch House Senior Living	Garden City	211.11	1.0416
Meadowbrook Rehab Hospital, LTCU	Gardner	271.43	1.2801
Medicalodges Gardner	Gardner	181.50	0.8615
Anderson County Hospital	Garnett	228.87	0.9031
Parkview Heights	Garnett	215.35	0.9750
Medicalodges Girard	Girard	186.74	0.9353
The Nicol Home, Inc.	Glasco	164.64	0.8066
Medicalodges Goddard	Goddard	199.73	0.9386
Bethesda Home	Goessel	221.53	1.0125
Good Samaritan Society-Sherman C	Goodland	191.02	0.9570
Medicalodges Great Bend	Great Bend	166.32	0.8985
Great Bend Health and Rehab Center	Great Bend	167.00	1.0230
Halstead Health and Rehab Center	Halstead	215.00	1.0429
Haviland Operator, LLC	Haviland	116.82	0.6472
Good Samaritan Society-Hays	Hays	203.43	1.0797
Via Christi Village-Hays	Hays	185.20	0.9559
Diversicare of Haysville	Haysville	179.88	1.2664
Legacy at Herington	Herington	178.55	1.1454
Schowalter Villa	Hesston	245.20	1.0300
Maple Heights of Hiawatha	Hiawatha	173.65	0.9426
Highland Healthcare and Rehab Center	Highland	189.77	1.2091
Dawson Place, Inc.	Hill City	181.88	0.9109
Salem Home	Hillsboro	216.21	1.1356
Parkside Homes, Inc.	Hillsboro	207.22	1.0208
Medicalodges Jackson County	Holton	195.04	0.9617
Mission Village Living Center	Horton	156.91	0.9297
Sheridan County Hospital	Hoxie	216.25	0.8730
Pioneer Manor	Hugoton	215.63	0.8823
Diversicare of Hutchinson	Hutchinson	187.17	1.0927
Good Sam Society-Hutchinson Village	Hutchinson	208.04	0.8944
Hutchinson Operator, LLC	Hutchinson	180.20	1.1274
Wesley Towers	Hutchinson	239.76	1.0303
Medicalodges Independence	Independence	183.70	0.9343
Montgomery Place Nursing Center, LLC	Independence	190.02	1.1824
Pleasant View Home	Inman	190.78	0.8847
Hodgeman Co Health Center-LTCU	Jetmore	228.24	1.0264
Stanton County Hospital-LTCU	Johnson	211.65	0.8490
Valley View Senior Life	Junction City	193.05	0.9561
Medicalodges Post Acute Care Center	Kansas City	189.16	1.0309
Riverbend Post Acute Rehabilitation	Kansas City	207.91	1.1648
Lifecare Center of Kansas City	Kansas City	186.80	0.9610
Providence Place LTCU	Kansas City	238.69	1.0224
Kansas City Transitional Care Center	Kansas City	229.09	1.1598
Golden Oaks Healthcare, Inc.	Kansas City	245.75	1.2676
The Wheatlands	Kingman	180.68	0.9476
Medicalodges Kinsley	Kinsley	216.20	1.0357
Kiowa District Manor	Kiowa	201.79	0.8030
Locust Grove Village	Lacrosse	195.29	0.8776
High Plains Retirement Village	Lakin	234.52	0.9897
Lansing Care and Rehab Center, LLC	Lansing	197.46	1.0630
Twin Oaks Health and Rehab	Lansing	203.26	1.0146
Diversicare of Larned	Larned	157.23	1.0821
Lawrence Presbyterian Manor	Lawrence	203.39	0.9259
Brandon Woods at Alvamar	Lawrence	200.11	0.9297
Pioneer Ridge Retirement Community	Lawrence	211.14	0.9580
Medicalodges Leavenworth	Leavenworth	187.72	0.9340
The Healthcare Resort of Leawood	Leawood	245.36	1.1760
Delmar Gardens of Lenexa	Lenexa	169.55	0.9773
Lakeview Village	Lenexa	248.36	1.1324
Westchester Village of Lenexa	Lenexa	208.79	0.8452
Leonardville Nursing Home	Leonardville	175.39	0.9344
Wichita County Health Center	Leoti	216.01	0.8915
Good Samaritan Society-Liberal	Liberal	181.04	1.0579
Wheatridge Park Care Center	Liberal	201.06	1.1097
Lincoln Park Manor, Inc.	Lincoln	199.28	0.8711
Bethany Home Association	Lindsborg	226.27	1.0056

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Facility Name	City	Daily Rate	Medicaid CMI
Linn Community Nursing Home	Linn	171.39	0.9531
Sandstone Heights Nursing Home	Little River	237.34	1.0324
Logan Manor Community Health Service	Logan	173.24	0.9064
Louisburg Healthcare and Rehab Center	Louisburg	200.22	1.1850
Good Samaritan Society-Lyons	Lyons	192.27	0.9092
Meadowlark Hills Retirement Community	Manhattan	232.17	0.9845
Stoneybrook Retirement Community	Manhattan	181.38	0.9092
Via Christi Village Manhattan, Inc.	Manhattan	190.72	0.9829
St. Luke Living Center	Marion	206.65	0.9514
Riverview Estates, Inc.	Marquette	187.23	0.8821
Cambridge Place	Marysville	163.38	0.9602
McPherson Operator, LLC	McPherson	171.20	1.0774
The Cedars, Inc.	McPherson	212.98	0.9414
Meade District Hospital, LTCU	Meade	239.81	1.0116
Trinity Nursing and Rehab Center	Merriam	203.13	1.0729
Great Plains of Ottawa County, Inc.	Minneapolis	215.84	0.8300
Minneapolis Health and Rehabilitation	Minneapolis	221.36	1.1484
Minneola District Hospital-LTCU	Minneola	213.27	0.8486
Bethel Home, Inc.	Montezuma	201.14	0.9566
Moran Manor	Moran	157.11	1.0860
Pine Village	Moundridge	210.92	1.0284
Moundridge Manor, Inc.	Moundridge	204.55	0.8822
Mt. Hope Nursing Center	Mt. Hope	185.26	0.9961
Villa Maria, Inc.	Mulvane	219.42	1.2034
Neodesha Care and Rehab Center, LLC	Neodesha	192.12	1.1383
Ness County Hospital District #2	Ness City	220.37	0.9607
Asbury Park	Newton	209.01	0.9584
Kansas Christian Home	Newton	205.18	0.9371
Newton Presbyterian Manor	Newton	212.35	0.9525
Bethel Care Center	North Newton	218.31	0.9575
Andbe Home, Inc.	Norton	186.60	0.9423
Village Villa	Nortonville	179.75	1.0835
Logan County Manor	Oakley	233.63	1.0234
Good Samaritan Society-Decatur County	Oberlin	205.64	0.8961
Villa St. Francis Catholic Care Center	Olathe	216.69	1.0724
Pinnacle Ridge Nursing and Rehabilitation	Olathe	187.40	1.0123
Azria Health at Olathe	Olathe	229.86	1.1132
Good Samaritan Society-Olathe	Olathe	212.96	0.9257
Evergreen Community of Johnson County	Olathe	232.64	0.9983
Aberdeen Village, Inc.	Olathe	233.44	0.9746
Nottingham Health and Rehab	Olathe	216.96	1.0382
The Healthcare Resort of Olathe	Olathe	233.85	1.1498
Onaga Operator, LLC	Onaga	181.58	1.2337
Osage Nursing and Rehab Center	Osage City	187.33	1.0592
Life Care Center of Osawatomie	Osawatomie	202.60	1.1854
Parkview Care Center	Osborne	160.65	0.9087
Hickory Pointe Care and Rehab Center	Oskaloosa	196.48	0.9669
Oswego Operator, LLC	Oswego	178.00	1.1809
Rock Creek of Ottawa	Ottawa	180.53	1.1358
Brookside Manor	Overbrook	162.60	1.0304
Garden Terrace at Overland Park	Overland Park	180.39	1.1660
Promise Skilled Nursing of Overland	Overland Park	251.98	1.6034
Serenity Rehab and Nursing Overland	Overland Park	228.30	1.1858
Villa Saint Joseph	Overland Park	239.59	1.0309
Delmar Gardens of Overland Park	Overland Park	195.15	0.9600
Overland Park Nursing and Rehab	Overland Park	228.25	1.1003
Indian Creek Healthcare Center	Overland Park	183.51	1.0897
Village Shalom, Inc.	Overland Park	240.06	1.0961
Tallgrass Creek, Inc.	Overland Park	263.01	1.2400
Shawnee Post Acute Rehab Center	Overland Park	242.95	1.1464
Stratford Commons Rehab and HCC	Overland Park	240.39	1.0514
Colonial Village	Overland Park	232.82	1.0416
ML-OP Oxford, LLC	Oxford	169.76	0.9225
Medicalodges Paola	Paola	133.98	0.7694
North Point Skilled Nursing Center	Paola	193.72	1.0783
Elmhaven East	Parsons	164.57	0.9130
Parsons Presbyterian Manor	Parsons	208.70	0.9584
Good Samaritan Society-Parsons	Parsons	191.46	0.9804
Peabody Operator, LLC	Peabody	154.36	1.0147
Franklin Healthcare of Peabody	Peabody	118.77	0.7089
Phillips County Retirement Center	Phillipsburg	177.66	0.8473
Medicalodges Pittsburg South	Pittsburg	188.40	0.9748
Pittsburg Care and Rehab Center, LLC	Pittsburg	198.02	1.0675
Via Christi Village Pittsburg, Inc	Pittsburg	195.70	1.0547
Rooks County Senior Services, Inc.	Plainville	193.93	0.9868
Brighton Gardens of Prairie Village	Prairie Village	220.82	1.1125
Pratt Regional Medical Center	Pratt	217.23	1.0200
Pratt Operator, LLC	Pratt	164.78	1.1794
Prairie Sunset Manor	Pretty Prairie	222.50	1.4388
Protection Valley Manor	Protection	141.77	0.7162
Gove County Medical Center	Quinter	231.17	0.9318
Grisell Memorial Hospital District #1-LTCU	Ransom	220.47	0.8845
Richmond Healthcare and Rehab Center	Richmond	199.48	1.2371
Fountainview Nursing and Rehab Center	Rose Hill	227.84	1.2524
Rossville Healthcare and Rehab Center	Rossville	206.74	1.2765
Wheatland Nursing and Rehab Center	Russell	166.91	0.9678
Russell Regional Hospital	Russell	221.49	0.8663
Sabetha Nursing Center	Sabetha	168.87	1.0427
Apostolic Christian Home	Sabetha	180.60	0.9713
Smoky Hill Rehabilitation Center	Salina	158.98	1.0072
Kenwood View Health and Rehab Center	Salina	190.03	1.0855
Salina Windsor SNF OPCO, LLC	Salina	177.57	1.0662
Pinnacle Park Nursing and Rehabilitation	Salina	170.76	1.1464
Salina Presbyterian Manor	Salina	185.31	0.9580
Holiday Resort of Salina	Salina	190.32	0.9829
Satanta District Hospital LTCU	Satanta	213.34	0.8714
Park Lane Nursing Home	Scott City	217.18	0.9927
Pleasant Valley Manor	Sedan	154.96	0.9161
Diversicare of Sedgwick	Sedgwick	186.46	1.1292
Crestview Nursing and Residential Living	Seneca	164.21	0.9726
Life Care Center of Seneca	Seneca	156.98	1.0524
Wallace County Community Center	Sharon Springs	218.27	1.0449
Shawnee Gardens Healthcare and Rehab	Shawnee	184.47	1.2421
Sharon Lane Health Services	Shawnee	186.55	0.9819
Brookdale Rosehill	Shawnee	268.62	1.3984
Smith County Memorial Hospital LTCU	Smith Center	216.75	0.8725
Smith Center Operator, LLC	Smith Center	165.23	1.0845
Mennonite Friendship Manor, Inc.	South Hutchinson	209.50	0.9561
Spring Hill Care and Rehab Center, LLC	Spring Hill	212.70	1.0377
Cheyenne County Village, Inc.	St. Francis	234.91	0.9981
Leisure Homestead at St. John	St. John	172.42	0.8280
Community Hospital of Onaga, LTCU	St. Mary's	207.06	0.9148
Prairie Mission Retirement Village	St. Paul	161.73	1.0037
Leisure Homestead at Stafford	Stafford	171.61	0.8999
Sterling Presbyterian Manor	Sterling	209.39	0.7801
Solomon Valley Manor	Stockton	185.17	0.9438
Legend Healthcare	Tonganoxie	171.58	1.0681
Brewster Health Center	Topeka	226.56	0.8967
Topeka Presbyterian Manor Inc.	Topeka	224.90	0.9821
Legacy on 10th Ave.	Topeka	182.69	1.2100
McCrite Plaza Health Center	Topeka	210.04	0.9288
Rolling Hills Health Center	Topeka	199.52	1.0234
Manorcare Health Services of Topeka	Topeka	215.16	1.1105
Tanglewood Nursing and Rehabilitation	Topeka	174.56	1.2359
Brighton Place West	Topeka	143.13	1.0204

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Facility Name	City	Daily Rate	Medicaid CMI
Countryside Health Center	Topeka	113.31	0.7585
Providence Living Center	Topeka	114.74	0.8403
Brighton Place North	Topeka	97.51	0.6835
Aldersgate Village	Topeka	231.95	1.0813
Plaza West Care Center, Inc.	Topeka	205.43	0.9947
Lexington Park Nursing and Post Acute	Topeka	216.60	0.8774
The Healthcare Resort of Topeka	Topeka	216.66	1.1982
Greeley County Hospital, LTCU	Tribune	214.33	0.9884
Western Prairie Senior Living	Ulysses	203.22	0.9134
Valley Health Care Center	Valley Falls	145.42	0.6100
Trego County Lemke Memorial LTCU	Wakeeney	213.09	0.8784
Wakefield Care and Rehab Center, LLC	Wakefield	208.43	1.0825
Good Samaritan Society-Valley Vista	Wamego	205.19	0.9513
The Centennial Homestead, Inc.	Washington	184.76	0.9827
Wathena Healthcare and Rehab Center	Wathena	200.61	1.3161
Coffey County Hospital	Waverly	205.41	1.0467
Wellington Care and Rehab Center, LLC	Wellington	191.16	1.0108
Sumner Operator, LLC	Wellington	167.80	1.0415
Wellsville Manor	Wellsville	151.69	1.0839
Westy Community Care Home	Westmoreland	156.24	0.8300
Wheat State Manor	Whitewater	186.39	0.9360
Medicalodges Wichita	Wichita	192.40	0.9536
Meridian Rehab and Health Care Center	Wichita	153.26	0.9827
Kansas Masonic Home	Wichita	211.78	1.0619
Homestead Health Center, Inc.	Wichita	222.93	0.9596
Woodlawn Care and Rehab, LLC	Wichita	176.04	0.9035
Wichita Presbyterian Manor	Wichita	214.25	0.9546
Sandpiper Healthcare and Rehab Center	Wichita	183.51	1.2714
Lakepoint Nursing and Rehabilitation	Wichita	172.95	0.9743
Manorcare Health Services of Wichita	Wichita	201.87	1.1555
Legacy at College Hill	Wichita	169.76	1.1107
Seville Operator, LLC	Wichita	188.83	1.1439
Wichita Care and Rehab Center, LLC	Wichita	211.52	1.0242
The Health Care Center at Larksfield Place	Wichita	210.20	0.8990
Life Care Center of Wichita	Wichita	209.51	1.1961
Family Health and Rehabilitation Center	Wichita	192.39	0.9680
Caritas Center	Wichita	213.48	0.8090
Regent Park Rehab and Healthcare	Wichita	236.14	1.1596
Avita Health and Rehab of Reeds Cove	Wichita	198.09	1.0198
Via Christi Village Ridge	Wichita	210.28	0.9868
Via Christi Village McLean, Inc.	Wichita	219.16	1.2844
Mount St Mary	Wichita	202.59	1.0416
Wilson Care and Rehab Center, LLC	Wilson	224.04	1.2237
F W Huston Medical Center	Winchester	155.02	0.9113
Winfield Senior Living Community	Winfield	207.45	1.0727
Cumbernauld Village, Inc.	Winfield	219.78	0.9140
Winfield Rest Haven II LLC	Winfield	219.61	1.0345
Kansas Veterans' Home	Winfield	201.50	0.9296
Yates Operator, LLC	Yates Center	174.58	1.2006

III. Justifications for the Rates

1. The proposed rates are calculated according to the rate-setting methodology in the Kansas Medicaid State Plan and pending amendments thereto.
2. The proposed rates are calculated according to a methodology which satisfies the requirements of K.S.A. 39-708c(x) and the DHCF regulations in K.A.R. Article 129-10 implementing that statute and applicable federal law.
3. The State's analyses project that the rates:
   a. Would result in payment, in the aggregate of 95.04% of the Medicaid day weighted average inflated allowable nursing facility costs statewide; and
   b. Would result in a maximum allowable rate of $234.29 (for a CMI of 1.0314); with the total average allowable cost being $192.09.
   c. Average Payment rate July 1, 2019 $192.09
   d. Average payment rate July 1, 2018 $190.24
   Amount of change $1.85
   Percent of change 0.97%
4. Estimated annual aggregate expenditures in the Medicaid nursing facility services payment program will increase approximately $4.41 million.
5. The state estimates that the rates will continue to make quality care and services available under the Medicaid State Plan at least to the extent that care and services are available to the general population in the geographic area. The state's analyses indicate:
   a. Service providers operating a total of 323 nursing facilities and hospital-based long-term care units (representing 96.42% of all the licensed nursing facilities and long-term care units in Kansas) participate in the Medicaid program;
   b. There is at least one Medicaid-certified nursing facility and/or nursing facility for mental health, or Medicaid-certified hospital-based long-term care unit in 100 of the 105 counties in Kansas;
   c. The statewide average occupancy rate for nursing facilities participating in Medicaid is 81.23%;
   d. The statewide average Medicaid occupancy rate for participating facilities is 57.05%; and
   e. The rates would cover 95.23% of the estimated Medicaid direct health care costs incurred by participating nursing facilities statewide.
6. Federal Medicaid regulations at 42 C.F.R. 447.272 impose an aggregate upper payment limit that states may pay for Medicaid nursing facility services. The state's analysis indicates that the methodology will result in compliance with the federal regulation.

IV. Request for Comments; Request for Copies

The state requests providers, beneficiaries and their representatives, and other concerned Kansas residents to review and comment on the proposed rates, the methodology used to calculate the proposed rates, the justifications for the proposed rates, and the intent to amend the Medicaid State Plan. Persons and organizations wishing to submit comments must mail, deliver, or fax their signed, written comments before the close of business on May 17, 2019 to:

Melissa Warfield
Director of Fiscal and Program Evaluation
Kansas Department for Aging and Disability Services
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404
Fax Number: 785-296-0256

(continued)

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V. Notice of Intent to Amend the Medicaid State Plan

The state intends to submit Medicaid State Plan amendments to CMS on or before September 30, 2019.

Laura Howard, Secretary
Department for Aging and Disability Services

Chris Swartz, Deputy Medicaid Director
Department of Health and Environment
Division of Health Care Finance

Doc. No. 047091

State of Kansas

Department of Transportation

Request for Comments

The Kansas Department of Transportation (KDOT) requests comments on the amendment of the Statewide Transportation Improvement Program (STIP) FY 19-22. The comprehensive list of project(s) being amended to the STIP may be viewed online at: http://www.ksdot.org/bureaus/burProgProjMgmt/stip/stip.asp. The project list includes projects for counties, cities, and projects on the state highway system.

The amendment of the STIP requires a public comment period of 14 days. To make comment on this STIP amendment, contact KDOT's Bureau of Program and Project Management, 2nd Floor Tower, 700 SW Harrison, Topeka, KS 66603-3754, phone 785-296-2252, fax 785-296-8168.

This information is available in alternative accessible formats. To obtain an alternative format, contact the KDOT Office of Public Affairs at 785-296-3585 (Voice/Hearing Impaired–711).

The comment period regarding the STIP amendment for these projects will conclude May 1st, 2019.

Julie Lorenz
Secretary

Doc. No. 047085

State of Kansas

Department for Children and Families

Request for Comments

The Kansas Department for Children and Families (DCF) will accept public comments on the State Fiscal 2020 Social Services Block Grant. A copy of the plan, paper or electronic, may be obtained by contacting Patti Cazier by telephone at 785-291-3080, by email at Patricia.Cazier@ks.gov, or under the Quick Links, Newsroom section of the DCF website: http://www.dcf.ks.gov/Newsroom. Comments must be submitted in writing and received by DCF by May 21, 2019.

Laura Howard
Secretary

Doc. No. 047063

State of Kansas

Office of the Governor

Executive Order No. 19-06
Governor's Reward for Information Regarding the Murder of James McFarland

WHEREAS, the Cherokee County Sheriff's Office and the Kansas Bureau of Investigation are investigating the April 30, 2017 death of James McFarland; and

WHEREAS, the Cherokee County Sheriff is working with local, state, and federal resources to locate Diana Marie Bohlander in connection with the investigation; and

WHEREAS, I have been informed by the KBI that Diana Marie Bohlander is considered to be a dangerous fugitive; and

WHEREAS, the Cherokee County Sheriff and the KBI believe that a Governor's Reward would facilitate the information gathering process and improve the likelihood of apprehending Diana Marie Bohlander before she commits additional serious offenses;

NOW, THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas by K.S.A 75-113, I do hereby offer a reward of Five Thousand Dollars ($5,000.00) for information leading to the apprehension of Diana Marie Bohlander.

This document shall be filed with the Secretary of State as Executive Order No. 19-06 and shall become effective immediately.

Dated April 4, 2019.

Laura Kelly
Governor

Doc. No. 047090

(Published in the Kansas Register April 18, 2019.)

City of Valley Center, Kansas

Summary Notice of Bond Sale
$3,980,000*
General Obligation Bonds, Series 2019-1

(General Obligation Bonds Payable from Unlimited Ad Valorem Taxes)

Bids

Subject to the Notice of Bond Sale dated April 2, 2019 (the "Notice"), facsimile and electronic bids will be received on behalf of the Clerk of the City of Valley Center, Kansas (the "Issuer") in the case of facsimile bids, at the address set forth below, and in the case of electronic bids, through PARITY® until 11:00 a.m. (CST) May 7, 2019, for the purchase of the above-referenced bonds (the "Bonds"). No bid of less than 100% of the principal amount of the Bonds and accrued interest thereon to the date of delivery will be considered.

Bond Details

The Bonds will consist of fully registered bonds in the denomination of $5,000 or any integral multiple thereof. The Bonds will be dated May 23, 2019, and will become due on December 1 in the years as follows:

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