Approved: 2-7-97
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Dave Kerr at 11:00 a.m. on January 29, 1997 in

Room 123-S of the Capitol.

All members were present except:

Committee staff present: Alan Conroy, Legislative Research Department
Kathy Porter, Legislative Research Department
Mark Burenheide, Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Revisor of Statutes
Judy Bromich, Administrative Assistant
Janet Henning, Committee Secretary

Conferees appearing before the committee: Phyllis Nolan, Chair, Board of Regents
Donald Hagen, M.D., Executive Vice Chancellor, Medical Center Campus
Wayne Lerner, Vice President, The Lash Group
Irene Cumming, Chief Executive Officer, KU Hospital

Others attending: See attached list

Senator Morris moved, Senator Lawrence seconded, that bill draft **7 RS 0227** be introduced as requested by SRS. The motion carried on a voice vote.

Phyllis Nolan, Chair, Board of Regents appeared before the Committee to explain the need to change the governance structure of the University of Kansas Hospital to respond to the rapidly changing health care market. Ms. Nolan advised the Committee that the Board of Regents has recommended that the Chancellor of the University of Kansas be authorized to proceed with the development of legislation to establish a public authority to operate the University of Kansas Hospital and that the Chancellor provide the proposed legislation to the Board for final approval prior to introduction to the legislature.

Dr. Don Hagen Executive Vice Chancellor, Medical Center Campus, explained to the Committee that the KU Medical Center is comprised of a hospital but also of a school of medicine, nursing, allied health and graduate studies and research. KU Medical Center currently has students in the first year medical school class from every regent's institution in Kansas and are serving patients from 101 counties in Kansas. In an attempt to formulate a plan, Dr. Hagen stated the group went to the University HealthSystem Consortium, a group of academic medical centers in America, They were asked for the top three consultants in the nation and after interviewing the three groups, the Lash group was chosen. Many of the recommendations made by this group will become the framework of legislation which would be proposed to the Legislature this session.

Dr. Wayne Lerner, Lash Group, informed the Committee of the detail findings and recommendations from a study conducted by Lash Group and KUMC (Attachment 1). Dr. Lerner explained to the Committee that consolidations of institutions, physicians/nurses groups, joint practice, and doctor groups are occurring as a result of insurance premium pressures. He also stated some states are implementing Medicaid managed care. In addition, medical centers such as KU are experiencing an evaporation of education subsidies. This is leading towards a reduced inpatient capacity. (Attachment 1-3).

Dr. Lerner illustrated to the Committee (Attachment 1-5) the KU hospital has the majority of the

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

market within their zip code. He stated 30% of the individuals living within the zip code of the KU Hospital utilize that facility. The market share for the secondary service area is 15-29.9% and the market share for the outlying service area is 5-14.9%.

Dr. Lerner explained to the Committee that what has happened with the payer/provider consolidation at KU and Kansas City (Attachment 1-6). Health Midwest has effectively created a system of institutions which bridge both sides of the state line. St. Luke's/Shawnee Mission have done the same. Columbia has more recently become more active in the Kansas City market and there is a myriad of independent institutions of which KU Hospital is one. It is the contention that it is very difficult with less than a 6% market share of the overall area, to maintain the clinical service of the institution much less hold its own as an independent partner in research and education.

KU Hospital has had, over the past two years, almost $22 million in bad debts or write-offs as a result of caring for uncompensated patients. This institution is at a disadvantage because it carries a load of participating in education, carries a load of participating in research, and carries a substantial community service load. All of this is not covered by any other single institution in an environment which is increasingly competitive from a clinical point of view (Attachment 1-7). As managed care penetration increases, pressure to reduce inpatient utilization will intensify.

In response to questions from the Committee, Dr. Lerner stated inpatient revenue will be further constrained as Medicare and other government payers shift to risk contracting. Hospital services, under traditional Medicare, goes from $.50 on the dollar spent to Medicare managed care, and spending less than $.20 on the dollar. Pre- and post-hospitalization services that institutions need to invest in are expanding from $.11 on the dollar to $.50 on the dollar (Attachment 1-10).

KU hospital is seeing a decline in the inpatient utilization (Attachment 1-11). Outpatient care has grown but has not off-set the revenue losses from reduced inpatient activity (Attachment 1-12). Dr. Lerner illustrated that the shift in KU Hospital's payer mix from Medicaid and commercial to managed care and self pay continues to reduce reimbursement (Attachment 1-13). Since 1993 KU Hospital has generated cumulative margins of over $26 million but available cash balances have increased only $7 million (Attachment 1-20).

Dr. Lerner stated there are12 areas (Attachment 1-21 and 1-22) of vulnerabilities which have been identified at KU Hospital:

* No defined linkage strategy
* Lack of service differentiation
* Declining admissions/minimal outpatient growth
* Shifting payment mechanisms
*No substantial subsidies for education
*Inadequate funding at federal and state level for charity care
*Limited cash reserves
*Limited management flexibility and decision autonomy
*Lack of timely access to capital
*Limited attractiveness to potential business partners
*Inefficient and costly operating practices
*Reduced innovation

The Lash group recommends of moving to a public authority model. It sustains the mission of KU Hospital, allows it to be interdependent with KU Medical Center, protects the public's assets, enhances the possibility of financial viability for that institution, allows the management to develop a culture that is already into serving the customer, and enhances the flexibility that allows for timely decision making (Attachment 1-28).

In response to questions from the Committee, Dr. Lerner advised that as a short term recommendation, it would not be advisable to sell the institution. He also stated the public or liability in a public authority does not have to be any greater than in a private corporation.

Irene Cumming, Chief Executive Officer, KU Hospital, clarified some of the vulnerabilities of KU Hospital by stating the staff had been downsized by 15% through attrition and it is felt that the FTE level has been tightened as much as possible. Indigent care continues to grow and is more costly.

SB 43: **Appropriations for FY97, supplemental appropriations for Departrment of Wildlife and Parks**

Senator Petty advised she had checked with several sources and determined a possibility of two payments: the first being in May, 1997 for approximately $5 million and the remaining payment would be made in the first six months of 1998. The 1998 payment (Attachment 2) would come from a cash carryover from '96-97 of approximately $3,750,000. There also was a carryover from EDIF of $1.2 million. That totals approximately $5 million for the payment in May. The remainder would be from the difference in actual expenditures in 96, the Governor's recommendation in '98, and it is approximately $1.3 million. The proposal would be that the additional $2 million would be garnered in savings as the 1998 budget is reviewed.

Senator Kerr advised the Committee that SB 43 would be held for evaluation until the next Committee meeting of February 3, 1997.

The meeting was adjourned at 12:20 p.m.

The next meeting is scheduled for February 3, 1997.

SENATE WAYS AND MEANS COMMITTEE GUEST LIST

DATE: 1-29-97

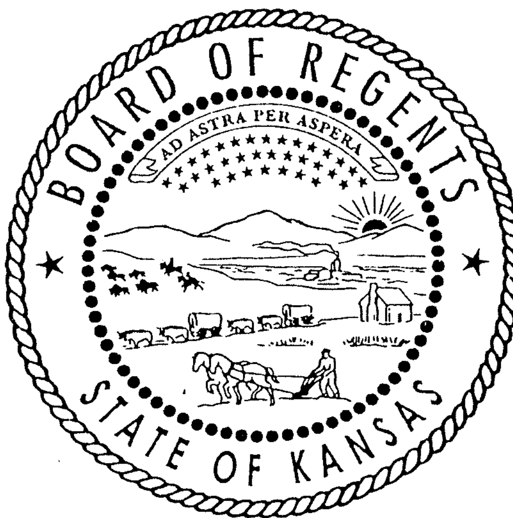
NAME	REPRESENTING
DICK CARTER, JR	KDWP
STEVE WILLIAMS	KDWP
Amelia McIntyre	KDWP
Dick Koerth	KDWP
Elaine Frisbie	Div. of the Budget
Dawn Reid	KSNA
CHRIS LAZZARINO	KANSAS ALUMNI MAGAZINE
Allen Humphrey	Depart. of Adm
Bob Mechtselman	SRS Medical Services
TK Shively	KANSAS LEGAL SERVICES
Ken Baler	Ks. Hospital Assn.
Ray Hauke	Staff, Ks Board of Regents
Barbara Brown	Intern - Sen. Salmans
Tom Bell	Ks. Hospital Ass.
Marlin Rein	KU
Jerry Slaughter	KMS
W. Corner	KU
DON HAGEN	KU
Phyllis Nolan	Ks. BoR

SENATE WAYS AND MEANS COMMITTEE GUEST LIST

DATE: ____________________________

NAME	REPRESENTING
Irene M Cumming	KU
Jon Jackson	KU
Rick Guthrie	Health Midwest
Marvin Burris	KBOR
Barb Conant	KBOR
Sen Tim Huelskamp	
Richard Watson MD	D.O.D.
Meg Hanson	KMS
Jon Josserand	KU

Senate Ways and Means Committee
Date 1-29-97
Attachment # 1



Report to the Board of Regents

The Need for Ownership/Governance Change at KU Hospital

January 22, 1997

Lash Group

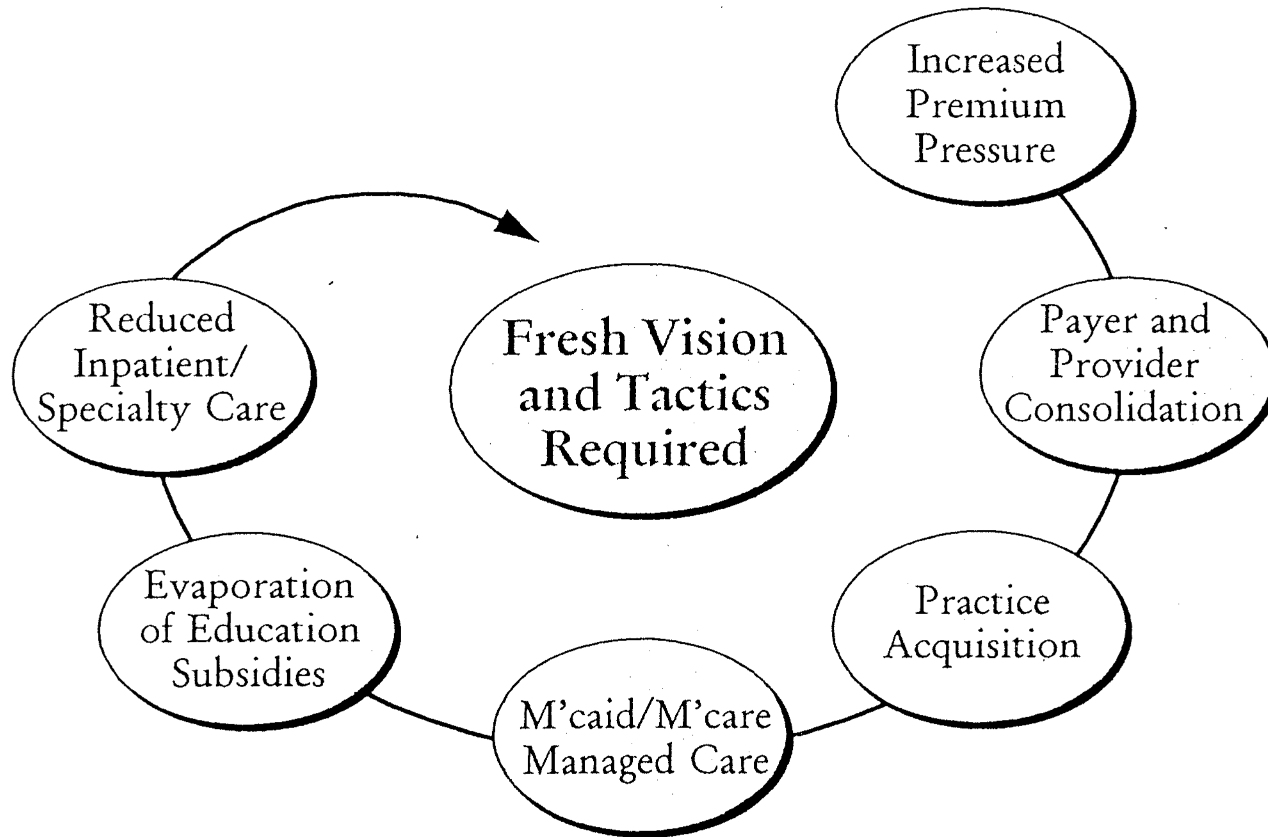
The following report details findings and recommendations from a study conducted by Lash Group and KUMC to address two questions.

- What issues must be addressed or barriers removed to ensure KU Hospital's ability to sustain and enhance its mission effectiveness in service, education, and research in a market increasingly characterized by managed care and heightened levels of competition?

- What ownership/governance structure best enables KUMC to serve the health related education and research needs and interests of the citizens of Kansas and maintain an economically viable clinical enterprise?

1-3

Health care continues its transformation to a market driven industry.



Source: University HealthSystem Consortium

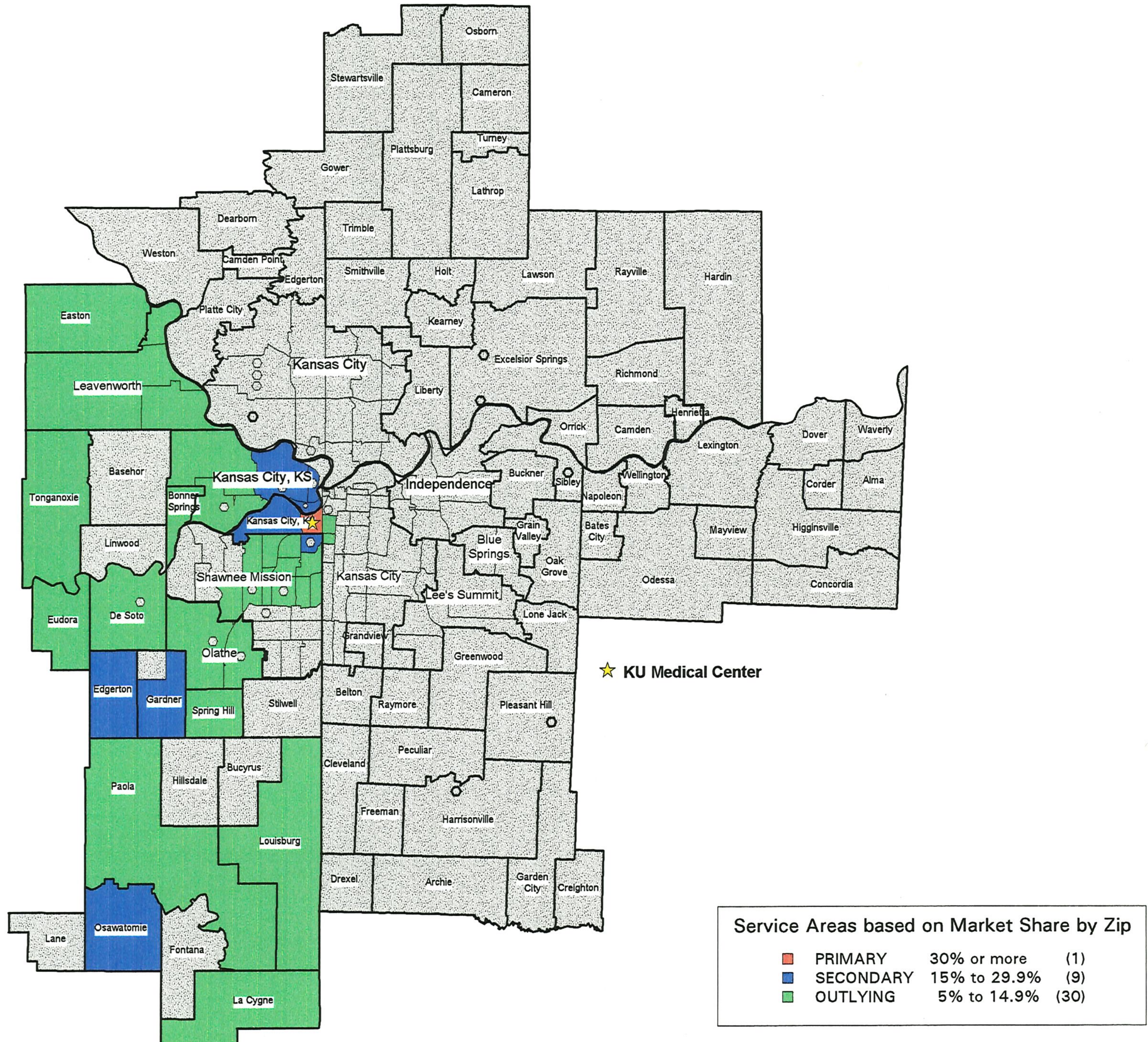
Using UHC's staging model, Kansas City has evolved into an early Stage III managed care market.

1-4

Stages	Stage I	Stage II	Stage III	Stage IV
	Unstructured	Loose Framework	Consolidation	Managed Competition
Characteristics	Independent hospitals, physicians, employers, and HMOs	Lead HMOs or PPOs emerge, loose provider networks and weak hospital affiliations form Excess inpatient capacity develops Hospital discounts widen	Lead HMOs or PPOs achieve critical mass, begin to consolidate; hospital systems form; all aggressively recruit/compete for primary care group practices Selective contracting by major purchasers Development of large multi-specialty, primary care, and IPA groups Specialist practices under-utilized; discounts increase Beds close, hospital profits increase	Purchasers contract with integrated hospital/physician systems to provide comprehensive services to their beneficiaries Financial risk shifts to primary medical groups/provider networks Beneficiaries have strong incentives to use contract network (extensive channeling) Capitation model becomes prevalent
Pricing	Fee for service (FFS)	Discount, per diem	Per diem, per case, physician capitation	Stage III plus capitation
Basis for Healthcare Purchasing	Encounter, cost of claim Volume	Encounter, cost of claim	Cost per covered life per health plan	Beneficiary health status, total healthcare costs

Source: University HealthSystem Consortium (UHC); Future stages still in development.

KU Medical Center Service Area



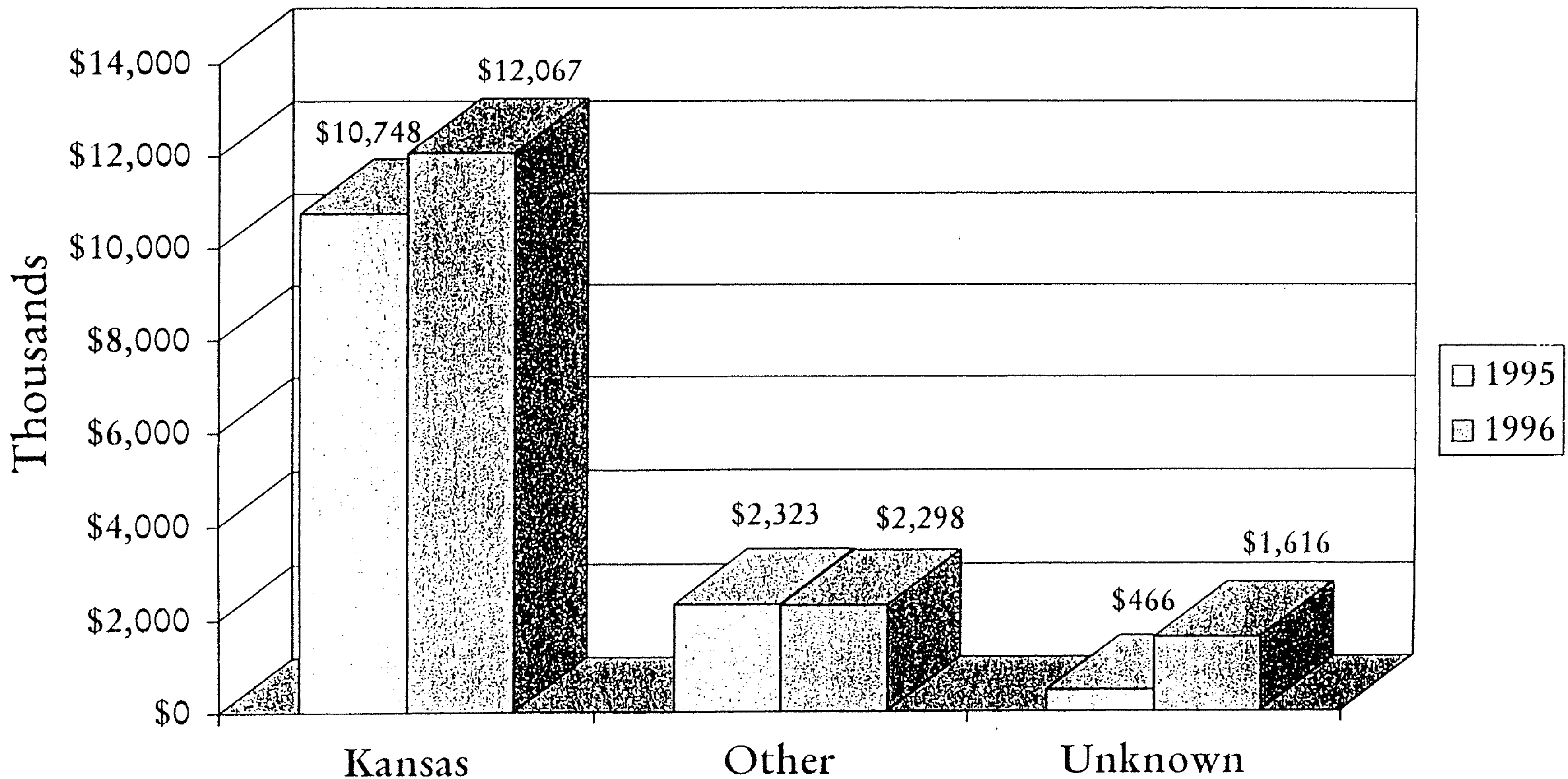
Business & Strategic Development 8/96

Lack of provider linkages and modest geographic coverage pose serious threats to KU Hospital and KUMC physicians.

Buchanan
Caldwell
Clinton
Atchison
St. Luke's/Shawnee
Pottawatomie
Jackson
Platte
Clay
Clay
Health Midwest
Jefferson
Leavenworth
Wyandotte
Shawnee
Health Midwest
Wabaunsee
Douglas
Johnson
Jackson
Lafayette
St. Luke's /Shawnee
Johnson
orris
Osage
Cass
Franklin
Miami
Lyon
Henry
Chase
Coffey
Anderson
Linn
Bates

KUMC

Over the past two years, KU Hospital had a total of 2,221 uninsured inpatient cases from 46 counties in Kansas, with write-offs totaling $22.7 million.*



* Based on gross charges. KU Hospital's overall cost-to-charge ratio approximates 60%.

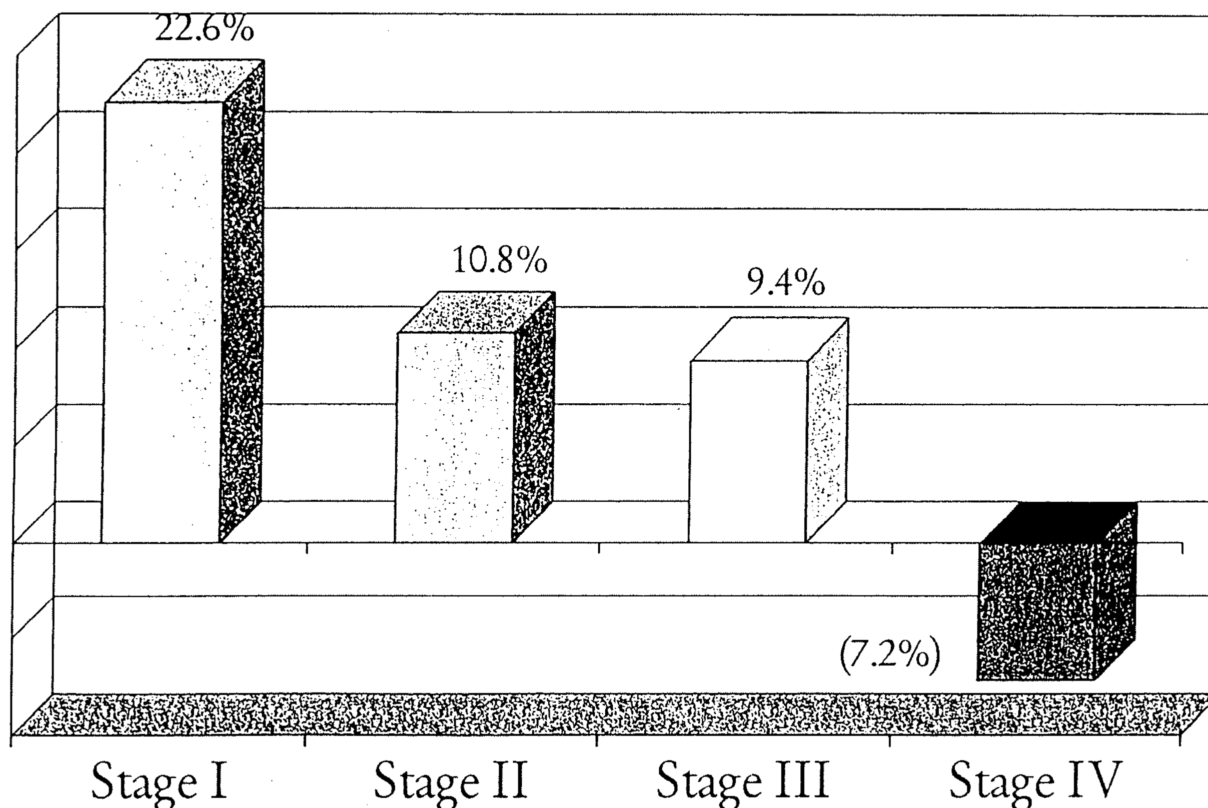
As managed care penetration increases, pressure to reduce inpatient utilization will intensify.

Comparison of Selected Market Characteristics by Stage

Location	Market Stage[1]	Hospital Days/ 1000 Population[2]	Beds/ 1000 Population[3]
Little Rock	II	1258.2	5.4
Indianapolis	III	992.5	3.8
Kansas City	III	818.0	3.9
Denver	IV	545.7	2.4
Tucson	IV	583.9	2.5
Minneapolis	IV	597.9	2.5
Portland	IV	469.4	1.9

Source: [1] *UHC*
[2] *The Competitive Edge, Part III: Regional Market Analysis*
[3] *1995/96 Hospital Stat: Emerging Trends in Hospitals*

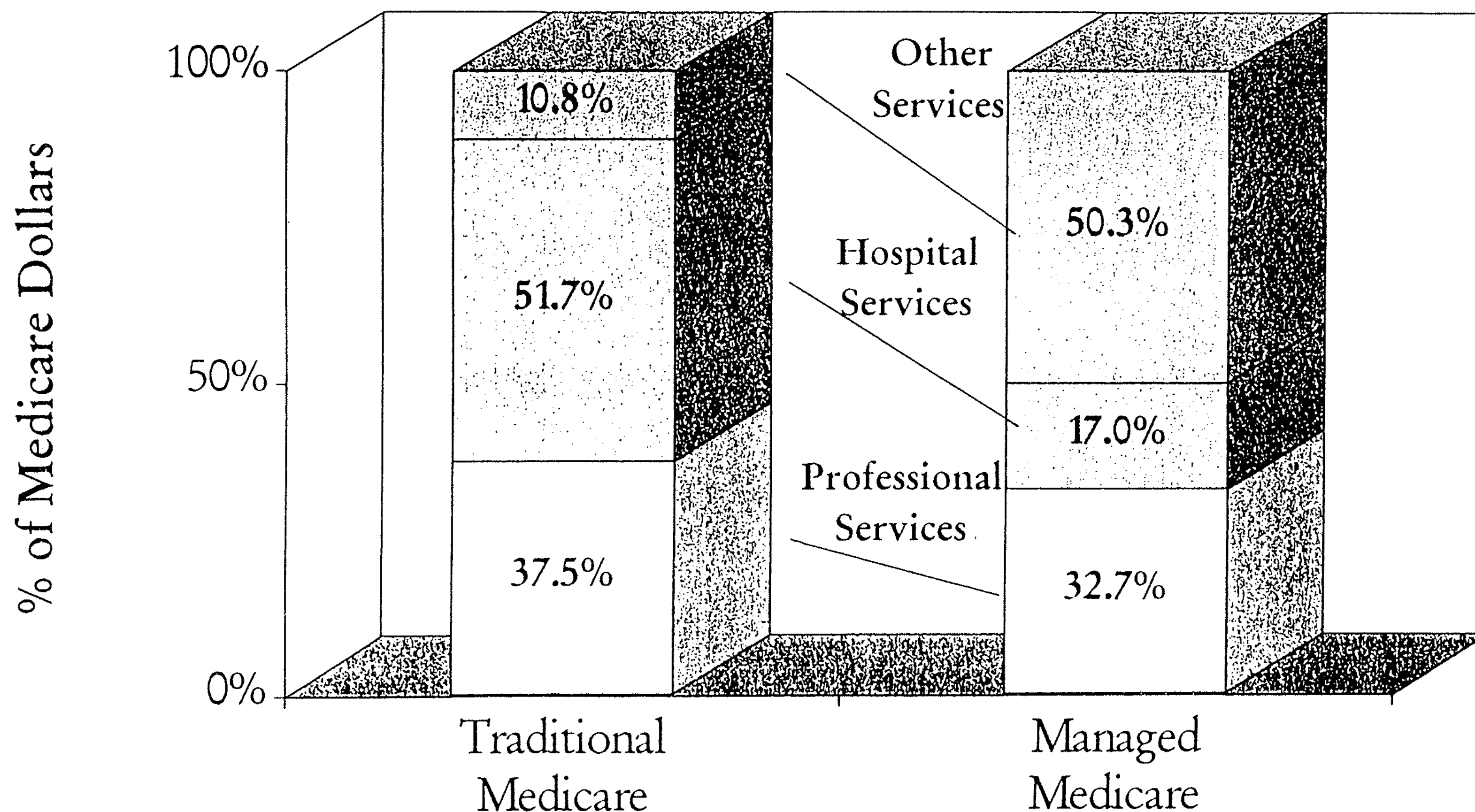
Declining inpatient use and deep price discounts have a significant impact on revenue potential in late stage markets.



Note: Does not reflect future changes in funding for government programs

Source: HCIA, UHC Financial Database

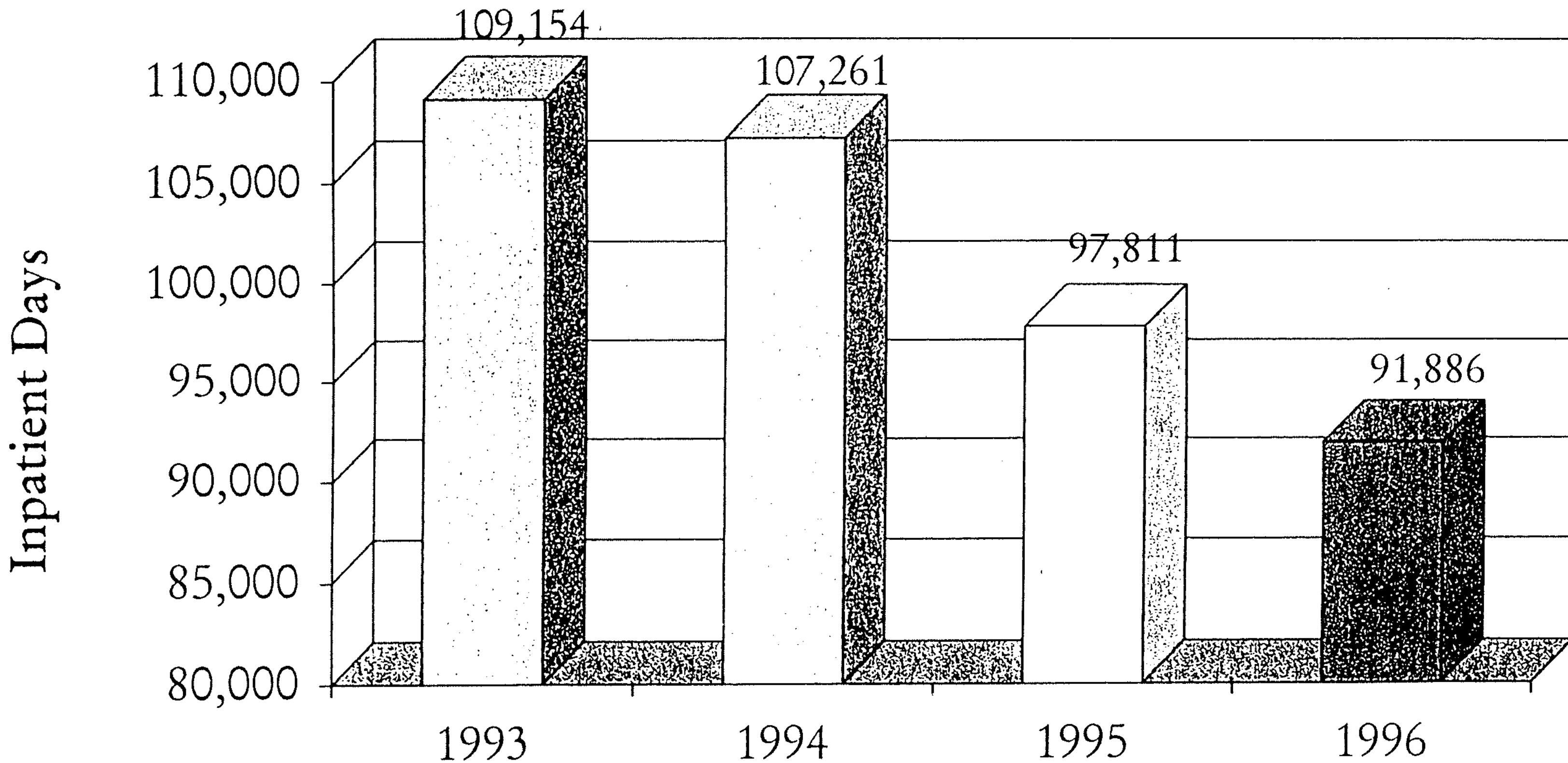
Inpatient revenue will be further constrained as Medicare and other government payers shift to risk contracting.



Whole dollar expenditures are greater with traditional Medicare.

Source: Stanford Health Services Model, UHC

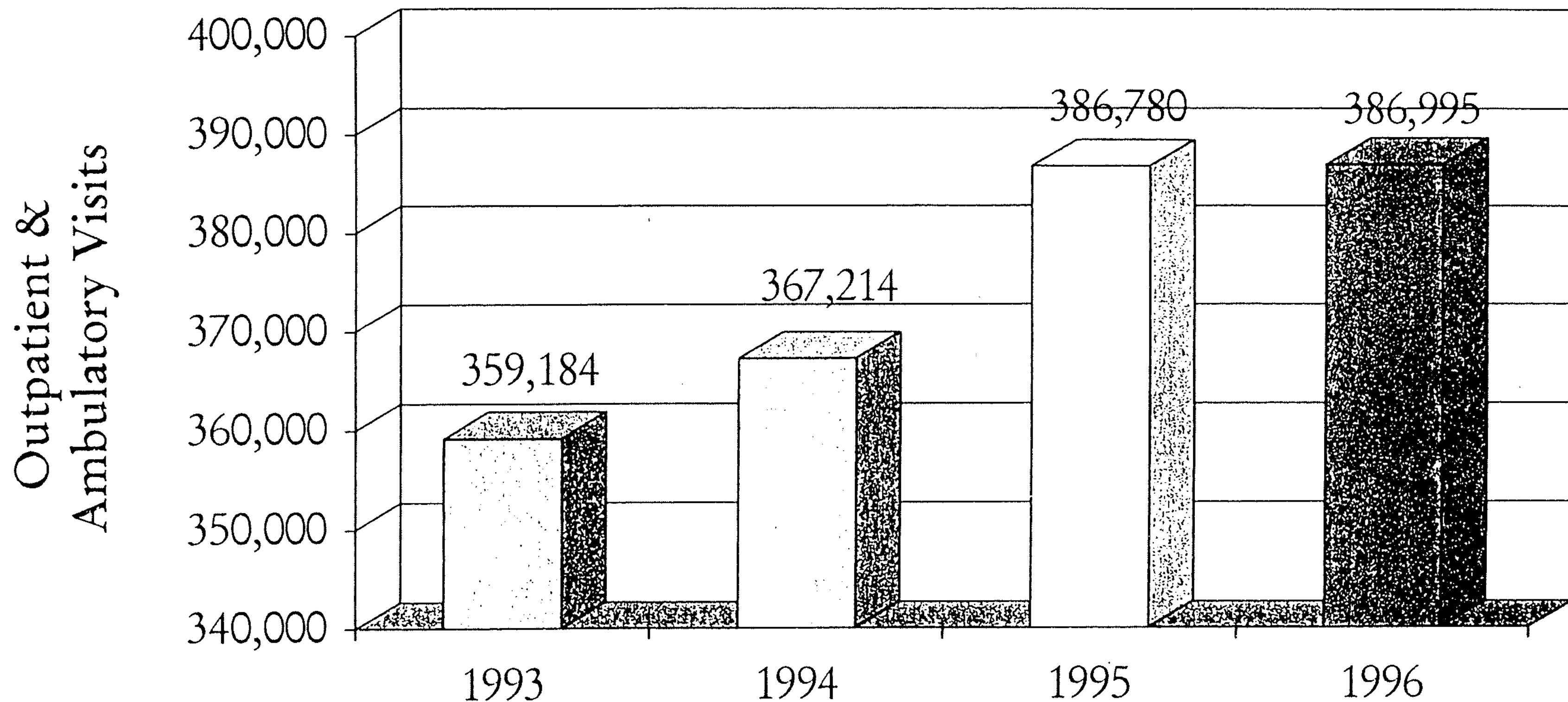
Declining admissions and length of stay have combined to significantly reduce KU Hospital's inpatient utilization.



Source: Hospital Statistics, 1993-1996 fiscal year

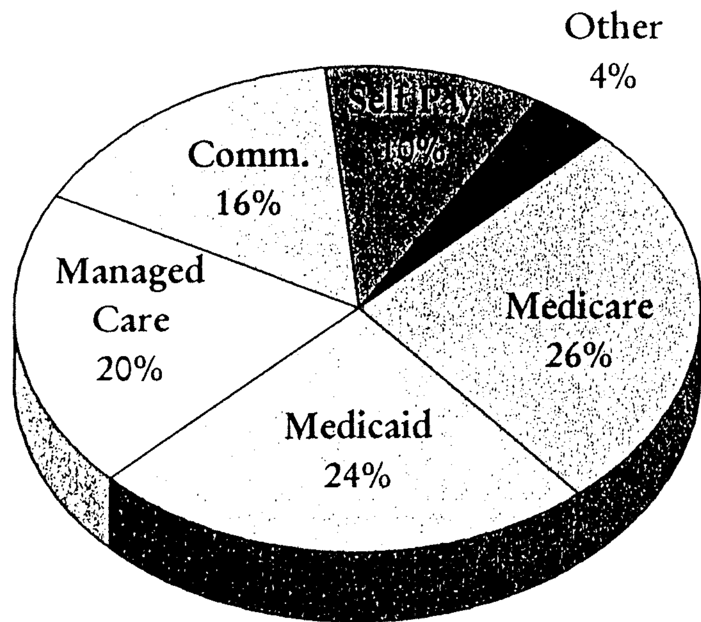
KU Hospital's outpatient utilization has grown, but has not off-set revenue losses from reduced inpatient activity.

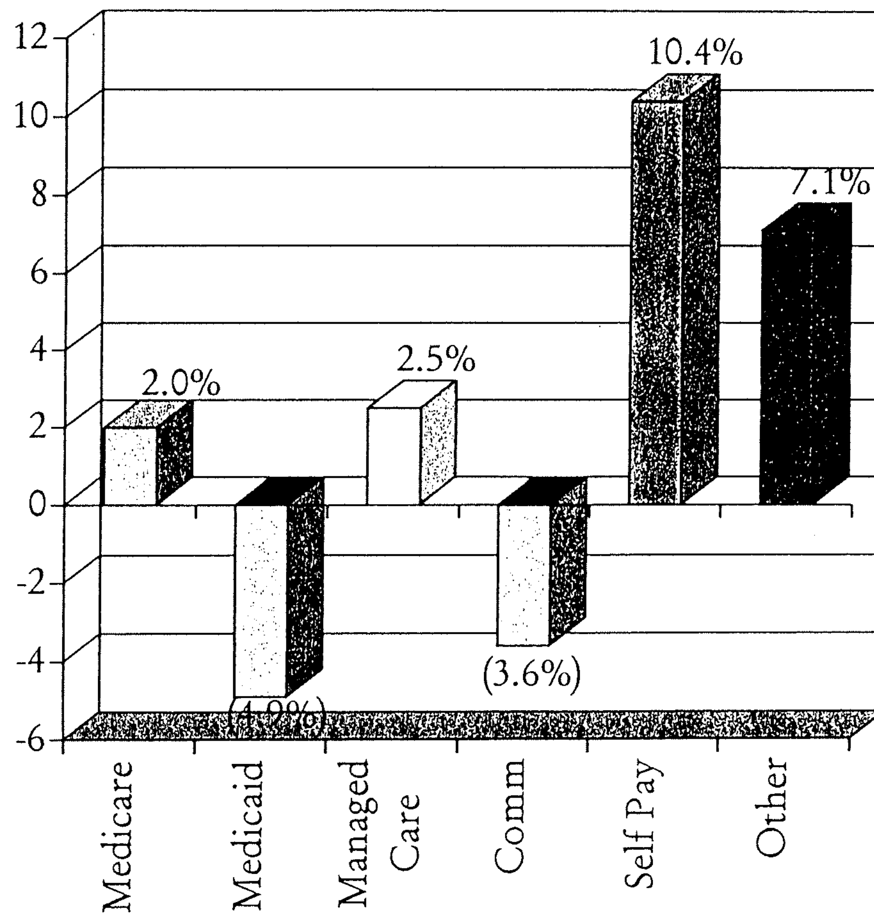
1-17



Source: Hospital Statistics, 1993-1996 fiscal year

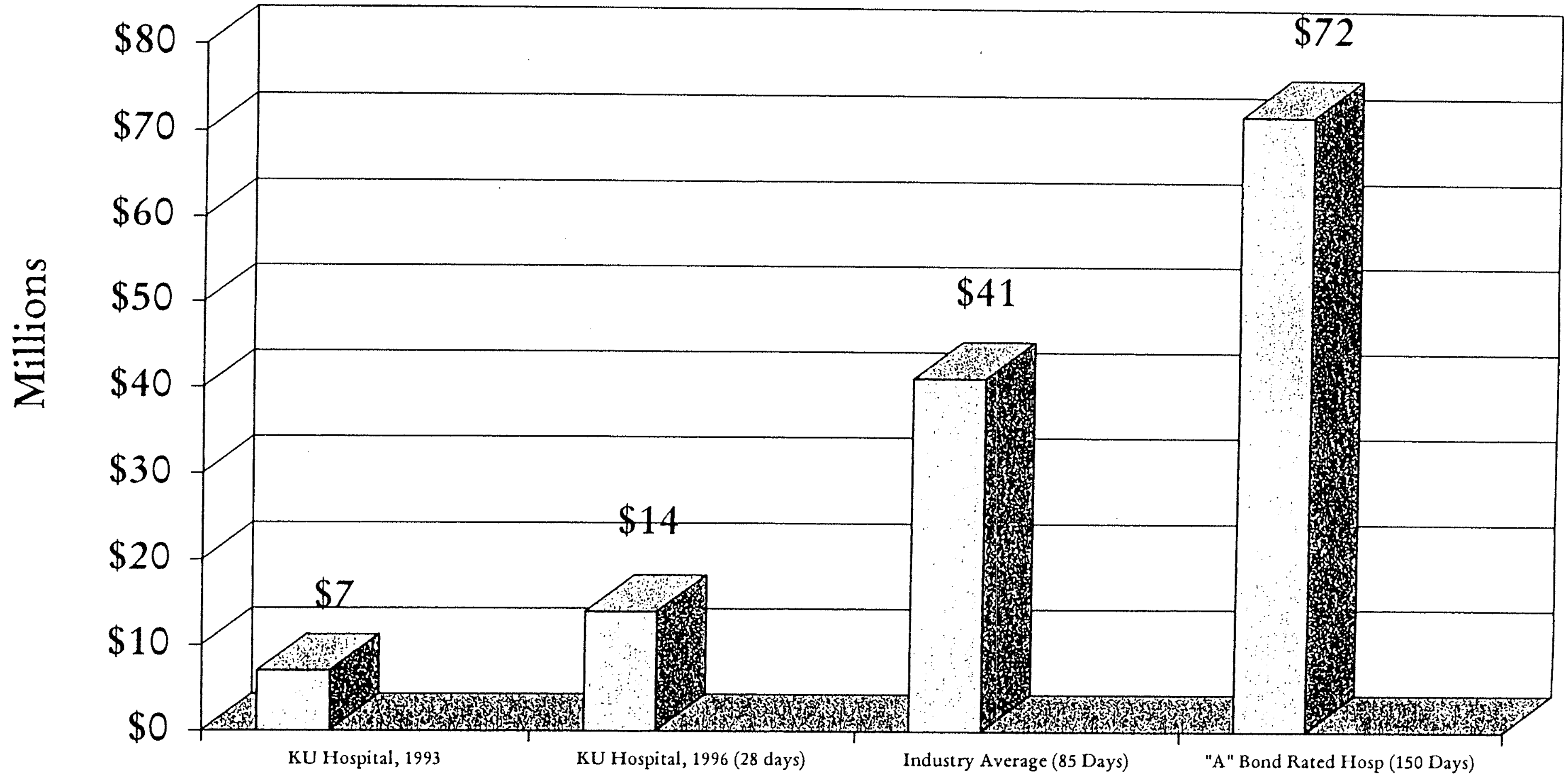
The shift in KU Hospital's payer mix from Medicaid and commercial to managed care and self pay continues to reduce reimbursement.





Source: Hospital Statistics, 1993-1996

ıce 1993, KU Hospital has generated cumulative margins of over $26 million, but available cash balances have increased only $7 million. This balance falls well below industry and "A" bond rated hospital averages.

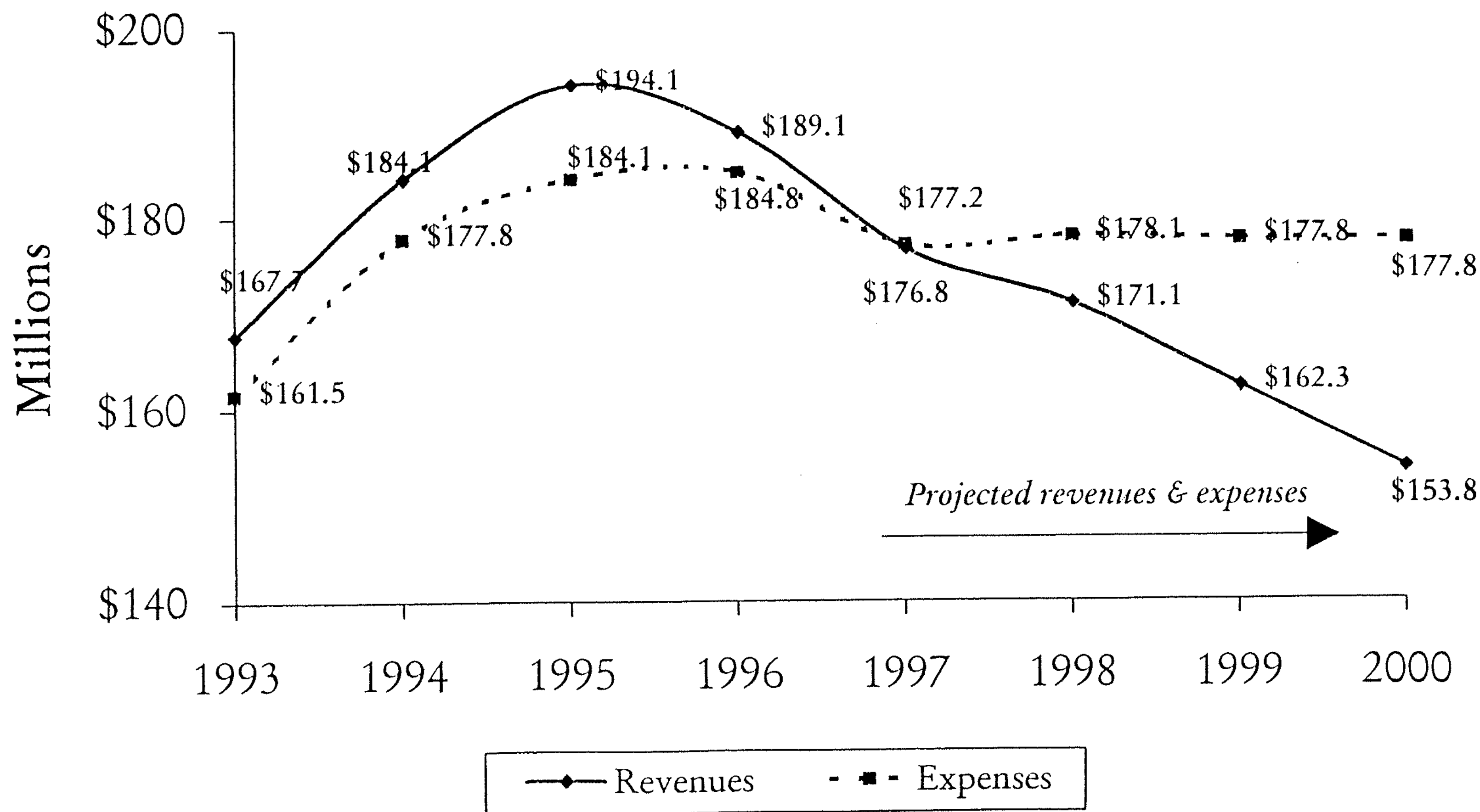


Source: *Hospital Statistics, 1993 - 1996*

The Center for Healthcare Industry Performance Studies (CHIPS)

Moody's Inventors Services

Projected baseline operating losses are substantial and cannot be reversed without significant market share growth and cost reduction initiatives.



Source: Hospital Statistics, 1993-1996
KU Hospital and Lash Group Projections

Over the past decade legislators have responded to KU Hospital's request for regulatory relief to address changing market conditions.

1-16

Legislative Change	Year	Relief Granted	Impact
Authority to move any classified position to unclassified status.	1980	Hospital unclassified positions in order to address salary constraints	Limited use because no funds were provided to offset expenses associated with benefits, retirement, and salary.
State established separate classifications for nursing personnel.	Early 1980's	Medical Center Nurse positions established with slightly higher salaries than at other state agencies	Provided short term relief - KUMC was not able to address continued escalation in salaries.
Authority to establish Health Care Employee category with unclassified service.	1989	Achieved salary freedom from state civil service pay structure while retaining benefits of classified employees	Hospital has taken advantage of opportunities available to reclassify employees into this category.
Removed expenditure limit from Hospital Revenue Fund.	1990	Hospital expenditures not limited by State appropriation	Hospital able to adjust its budget to support program needs subject to availability of adequate hospital revenue.
Granted KU Hospital authority to negotiate, enter into contracts and leases for purposes of affiliation, joint ventures, partnerships, and equity ownerships with other health care providers and third parties for purposes of providing medical services or partricipation in medical networks. *	1995 SB 171	Exempted such ventures from state purchasing statutes	Ventures subject to Board of Regents approval. Hospital used this authority to develop Jayhawk Primary Care.

uthority for change initially granted through proviso and later made statutory

Regulatory relief (continued)

1-17

Legislative Change	Year	Relief Granted	Impact
Exemption from state purchasing approval for all acquisitions of data processing hardware or software by KUMC for KU Hospital. *	1995 SB 170	Allows sole source acquisition.	Requires medical center to file plan for future acquisitions with Director of Purchases. SMS contract negotiated under this exemption.
Authority to enter into contracts to lease and operate off campus medical care facilities. *	1995 SB 173	Leases not subject to state purchasing statutes or approval of Secretary of Administration.	
Authority to make direct purchases for goods and services in amounts up to $25,000 for any individual purchase.	1995 SB 174		Not very effective because very few purchases are between $10,000 and $25,000.
Authority to enter into contracts with consortiums of health care providers and other purchasing groups for acquisition of supplies and other materials.	1995 SB 174	Enabled hospital to go into contract with UHC.	
Authority to make expenditures for renovations, remodeling, or improvements to existing hospital physical plant from Hospital Reserve Fund.	1995 Proviso to Appropriation Bill on Hospital Reserve Fund	Able to expend moneys for capital improvements without a specific appropriation and allowed to make capital expenditures from general operating appropriations.	Subject to approval of Board of Regents and Department of Administration, expenditures must be presented to Joint Legislative Committee on State Building Construction.

* Authority for change initially granted through proviso and later made statutory

Source: Correspondence from KUMC 9/25/96

Regulatory barriers remain, however, and continue to threaten KU Hospital by reducing its ability to rapidly develop and implement strategic initiatives.

1-18

Industry experts note that government owned teaching hospitals require greater management flexibility in five areas to address market conditions. KU Hospital lacks management flexibility and decision making autonomy in four of the five areas.

- [x] Capital financing and acquisition strategies
- [x] Human resources management
- [x] Procurement practices
- [x] Information system development
- [ ] Managed care contracting

Source: The Webb Associates/Arthur Andersen, 1994

1-19

Regulation intended to ensure fair business practices and to protect public assets has a number of unintended consequences within KU Hospital.

Internal - Operational inefficiencies

- Lack of flexibility to manage personnel for maximum productivity
- Constrained development of state-of-the-art administrative and support services
- Service delays, interruptions, and re-work which negatively affect clinical service delivery and increase operating costs
- Inter-departmental conflict over customer service priorities -- internal (hospital) versus external (state)

External - Limited attractiveness as a potential business partner

- High fixed administrative and personnel costs
- Complex and time consuming decision making processes
- Limited access to capital
- Limited debt management capacity
- Increased costs of running dual accounting systems to meet state and Medicare requirements (cost based and accrual)
- Outdated and labor intensive procurement practices

1-20

In summary, KU Hospital must overcome a significant number of vulnerabilities to sustain mission effectiveness under new market conditions.

- **Vulnerability 1** - No defined linkage strategy

  Providers are rapidly consolidating in the Kansas City market. The absence of a strategic partnership places KU Hospital in an "at risk" position.

- **Vulnerability 2** - Lack of service differentiation

  KU Hospital is not perceived to be strongly differentiated in the market by unique services or by quality of care delivery. This perceived lack of differentiation limits the hospital's negotiating leverage with payers.

- **Vulnerability 3** - Declining admissions/minimal outpatient growth

  Changing market dynamics will likely contribute to a material erosion of KU Hospital's inpatient utilization to below break-even levels.

- **Vulnerability 4** - Shifting payment mechanisms

  Growth of managed care and risk based contracts has shifted payment from fee for service to fixed payments. Aggressive negotiations are reducing already dangerously narrow margins at many teaching hospitals.

Vulnerabilities (continued)

- **Vulnerability 5 - Eroding subsidies for education**

  Historical income sources for the cross-subsidization of education and research from patient care revenues are eroding.

- **Vulnerability 6 - Inadequate funding for charity care**

  KU Hospital receives no state support for uncompensated care for indigent patients. The hospital's ability to support this important part of its teaching and service mission is becoming endangered.

- **Vulnerability 7 - Limited cash reserves**

  KU Hospital cannot close projected revenue gaps through expense management alone. KU Hospital must be able to obtain the capital, either internal or external, necessary to make investments needed to increase market share and develop clinical initiatives that provide service differentiation.

- **Vulnerability 8 - Limited management flexibility and decision autonomy**

  KU Hospital is subject to a significant degree of state government oversight of all aspects of its operation, limiting managerial autonomy in a market that demands rapid decision making.

Vulnerabilities (continued)

- <u>Vulnerability 9</u> - Lack of timely access to capital

KU Hospital must receive legislative approval for bond indebtedness. Competitors are able to access the same debt markets using the same conduit - Kansas Development Finance Authority (KDFA) - without incurring the time required for legislative approval.

- <u>Vulnerability 10</u> - Limited attractiveness to potential business partners

Private sector providers are unlikely to partner with an institution whose strategic agenda and operating practices are constrained by a high degree of regulatory control.

- <u>Vulnerability 11</u> - Inefficient and costly operating practices

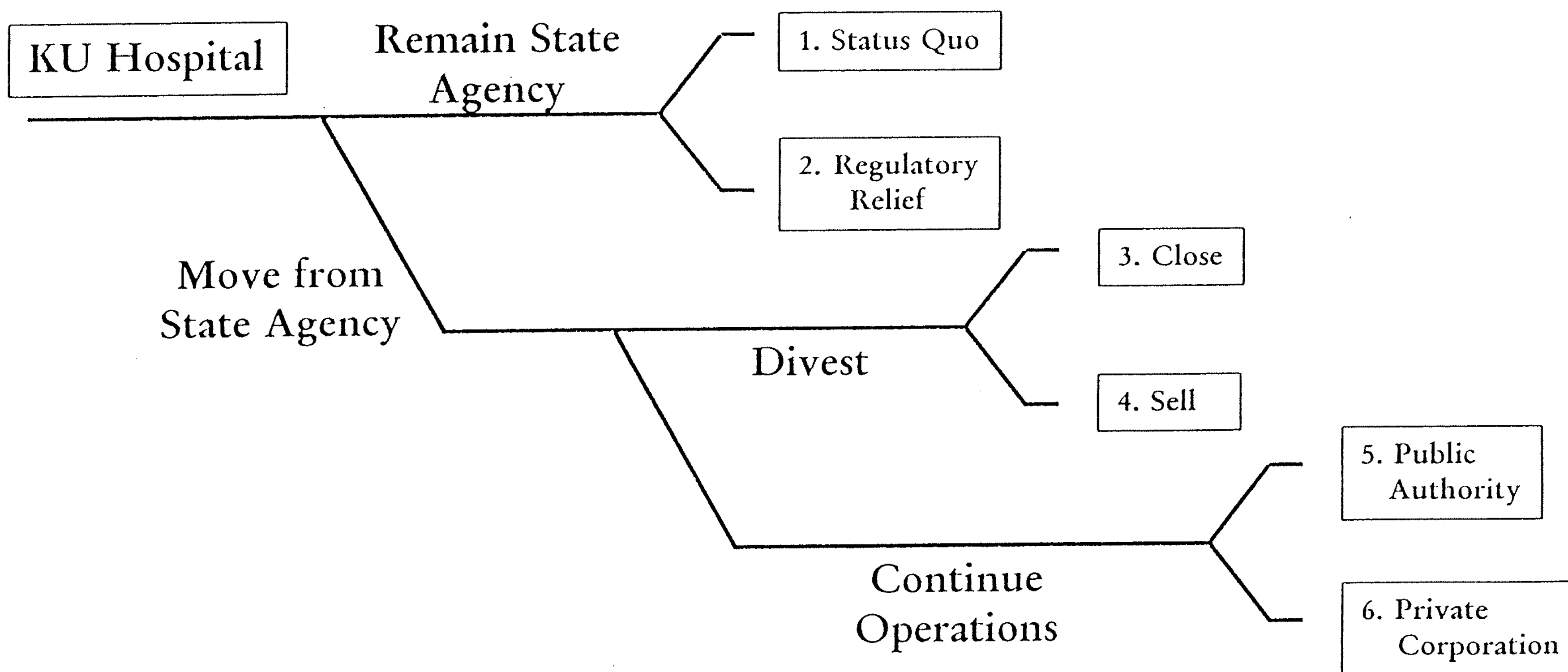
State regulations and administrative practices add complexity and cost to department operations as compared to private sector operations, resulting in inefficient use of scarce resources and poor internal customer satisfaction.

- <u>Vulnerability 12</u> - Reduced innovation

Introducing cost saving innovations in departments with a high degree of state oversight is difficult and time consuming. State regulation establishes an organizational climate in which managers believe they have little ability to "think outside the box", resulting in status quo operations in a rapidly changing industry.

1-23

Six change options grouped in three categories are typically considered.



Six teaching hospitals operating under differing ownership/governance models were studied to gain insight into model attributes and their impact on organizational performance.

1-34

- University of Arkansas -- regulatory relief model
- Indiana University Hospitals-- divestiture (merger)
- University of Minnesota -- divestiture (sale)
- University of Colorado Hospital -- public authority
- Oregon Health Sciences University -- public authority
- University of Arizona Health Sciences Center -- private corporation

Market conditions for each study site varied but those in more advanced managed care markets instituted ownership/ governance change in response to current or anticipated economic pressures.

Market	% HMO Enrollment[1]	Average Length of Stay[1]	Admits/ 1000 pop.[2]	Hospital Days/ 1000 pop.[1]	Beds/ 1000 pop.[2]	Primary Care Physicians/ 1000 pop.[3]	Specialist Physicians/ 1000 pop.[3]
Little Rock	13.6	7.0	179.9	1258.2	5.4	1.6	2.7
Indianapolis	16.6	6.6	150.4	992.5	3.8	1.1	1.5
Kansas City	**20.9**	**7.1**	**115.2**	**818.0**	**3.9**	**1.0**	**1.3**
Denver	27.4	5.6	97.4	545.7	2.4	1.0	1.4
Portland	41.8	4.9	95.8	469.4	1.9	0.9	1.4
Minneapolis	39.4	6.3	104.1	597.9	2.5	0.77	0.96
Tuscon	42.0	5.1	114.5	583.9	2.5	1.2	1.6
Group Average	**28.81**	**6.09**	**122.47**	**752.23**	**3.2**	**1.08**	**1.55**

[1] Source: The InterStudy Competitive Edge, Part III: Regional Market Analysis
[2] Source: 1995/96 Hospital Stat: Emerging Trends in Hospitals
[3] Source: Claritas, Inc: 1995 MEDEC Physician List and Database -- includes FPs, GPs, Internists, OB/GYNs, and Peds; Minnesota Medical Association
NOTE: data is not case mix adjusted)

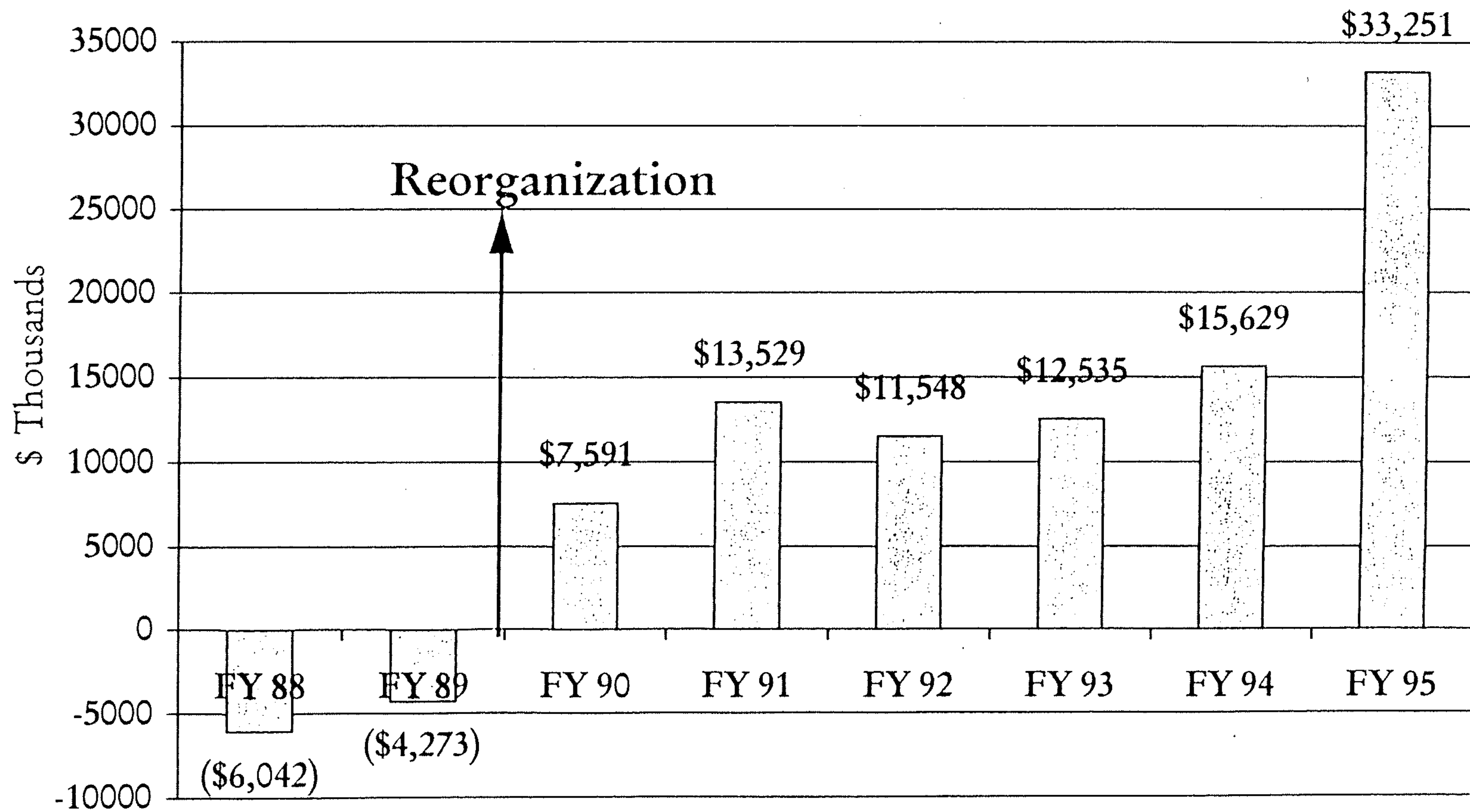
11-26

Several consistent themes emerged from the case studies.

- Two factors drove the decision for change in nearly all settings:
  - Inadequate access to capital to invest in programs
  - Inability to respond to market conditions in a timely manner
- Conversion to a new structure resulted in significantly greater managerial autonomy, but all states retained some degree of reserve power.
- Hospital performance improvements were swift and sustained.
- The change process required consensus building which took time, attention, and patience from all organizational leaders.

UH net income has been positive every year since the reorganization.

Net losses prior to the reorganization have turned to substantial net income.



Public Authority Advantages

1-28

- Meets identified goals for an ownership/governance change:
  - Sustains mission effectiveness
  - Protects public assets
  - Maintains financial viability for hospital
  - Develops a customer driven culture
  - Enhances management/governance flexibility and timely decision making
  - Supports ease of implementation

Status of the State Water Plan Fund

Agency/Program	Actual FY 1996	Gov Rec. FY 1997	Gov Rec. FY 1998
Beginning Balance	$ 1,093,957	$ 338,426	$ 1,648,848
Receipts			
State General Fund	$ 6,000,000	$ 6,000,000	$ 6,000,000
EDIF	2,000,000	2,000,000	2,000,000
Municipal Fees	3,292,606	3,426,804	3,390,558
Industrial Fees	1,128,911	1,129,006	1,135,000
Stock Water Fees	241,777	286,880	232,965
Fertilizer Fees	2,504,117	2,345,070	2,330,070
Pesticide Fees	860,000	845,000	845,000
Fines	9,470	12,000	12,000
Refund - Small Lakes	–	–	–
Released Encumberance	39,277	1,275,901	–
Sand Royalties	96,160	288,307	290,650
Subtotal - Receipts	$ 16,172,318	$ 17,608,968	$ 16,236,243
Cash Carryforward (from Agencies)	$ 1,510,030	$ 3,750,223	–
Total Available	$ 18,776,305	$ 21,697,617	$ 17,885,091
Less Transfers:			
State Conservation Commission	$ 9,815,970	$ 11,122,784	$ 9,766,500
Kansas Water Office	1,955,013	2,027,960	2,319,212
Water Marketing Fund	–	–	–
Wildlife and Parks	1,927,293	667,304	105,833
University of Kansas	193,386	8,030	0
Department of Agriculture	901,063	1,150,184	975,056
Health and Environment	3,645,154	4,620,000	4,253,398
Kansas State University	–	27,507	–
Department of Education	–	25,000	–
Corporation Commission	–	400,000	400,000
Subtotal - Transfers	$ 18,437,879	$ 20,048,769	$ 17,819,999
Ending Balance	$ 338,426	$ 1,648,848	$ 65,092

Senate Ways and Means Committee

Date 1-29-97

Attachment # 2

EXPENDITURES FROM THE STATE WATER PLAN FUND
FY 1996 - FY 1998

Agency/Program	Actual FY 1996	Agency Estimate FY 1997	Gov Rec. FY 1997	Agency Request FY 1998	Gov Rec. FY 1998	Change From FY 1996 to Gov. Rec. FY 1998
State Conservation Commission						
Conservation District Aid	$ 1,006,456	$ 1,008,892	$ 1,008,892	$ 1,016,500	$ 1,016,500	$ 10,044
Watershed Dam Construction	880,548	1,159,871	1,059,871	1,000,000	800,000	(80,548)
Multipurpose Small Lakes	645,604	800,000	800,000	800,000	517,900	(127,704)
Nonpoint Source Pollution Asst.	2,177,623	3,186,418	2,686,418	3,027,488	2,482,100	304,477
Water Resources Cost Share	4,997,200	5,527,535	5,327,535	5,200,000	4,800,000	(197,200)
Riparian and Wetland Program	97,229	278,758	212,008	100,000	100,000	2,771
Watershed Planning Assistance	11,310	11,310	11,310	50,000	50,000	38,690
Other Operating Expenditures	–	16,750	16,750	0	–	0
Total - Conservation Commission	$ 9,815,970	$ 11,989,534	$ 11,122,784	$ 11,193,988	$ 9,766,500	$ (49,470)
Kansas Water Office						
River Sub-basin Projects	$ 175,000	$ 70,000	$ 70,000	$ 76,000	$ 70,000	$ (105,000)
Mineral/Salt Water Intrusion Studies	95,200	50,000	50,000	50,000	40,000	(55,200)
Tech. Assist. to Water Users	205,652	226,015	226,015	425,000	225,000	19,348
Basin Assessment	–	20,000	20,000	55,330	40,000	40,000
Water Quality Planning Assist.	–	20,000	20,000	20,000	20,000	20,000
Geography Resource Center	50,000	50,000	50,000	50,000	50,000	0
Stream Gauging Program	302,175	331,275	331,275	350,000	346,000	43,825
GIS Manager, Data Base, and Support	434,821	497,317	497,317	452,536	448,012	13,191
Public Information	14,238	20,000	20,000	30,000	30,000	15,762
Storage – O&M	166,766	276,796	276,796	395,200	395,200	228,434
Weather Modification	190,000	92,000	92,000	390,000	390,000	200,000
Quality/Declines UARK River	35,000	75,000	75,000	75,000	75,000	40,000
Public Water Supply	20,017	10,157	10,157	10,000	10,000	(10,017)
Water Quality Initiative	248,144	244,400	244,400	25,000	25,000	(223,144)
Watershed Dam Hydrological Impact	18,000	45,000	45,000	55,000	55,000	37,000
Feedlot Water Quality	–	–	–	100,000	100,000	100,000
Milford & Perry Storage Princ. & Int.	–	–	–	840,850	–	0
Milford & Perry O&M	–	–	–	255,650	–	0
Total - Kansas Water Office	$ 1,955,013	$ 2,027,960	$ 2,027,960	$ 3,655,566	$ 2,319,212	$ 364,199
Wildlife and Parks						
Cheyenne Bottoms Renovation	$ 1,767,282	$ 507,366	$ 507,366	$ –	$ –	$ *
Hillsdale Reservoir	13,639	–	–	–	–	(13,639)
Neosho Madtom/Stream Monitor.	128,154	53,699	53,699	50,000	50,000	(78,154)
Rip-rap Cheney	18,218	31,239	31,239	–	–	(18,218)
Conservation Easments	–	130,833	75,000	–	55,833	55,833
Miami State Fishing Lake	–	–	–	500,000	–	0
Total - Wildlife and Parks	$ 1,927,293	$ 723,137	$ 667,304	$ 550,000	$ 105,833	$ (54,178)
University of Kansas						
Dakota Aquifer Study/Research	$ 193,386	$ 8,030	$ 8,030	$ 0	$ 0	$ 0
Kansas State University						
Ogallala Aquifer Study	$ 0	$ 27,507	$ 27,507	$ 28,057	$ 0	$ 0
Board of Agriculture						
Floodplain Management	$ –	$ 59,228	$ 59,228	$ 53,755	$ 50,260	$ 50,260
Interstate Water Issues	245,960	391,680	391,680	405,340	381,981	136,021
Nonpoint Source–Statistics	–	20,000	20,000	–	–	0
Subbasin Management Plan	460,789	642,228	642,228	559,054	542,815	82,026
Water Rights Information System	46,398	37,048	37,048	–	–	(46,398)
Water Rights Backlog	147,916	–	–	–	–	(147,916)
Total - Board of Agriculture	$ 901,063	$ 1,150,184	$ 1,150,184	$ 1,018,149	$ 975,056	$ 73,993
Health and Environment						
Contamination Remediation	$ 1,119,238	$ 1,800,000	$ 1,800,000	$ 1,818,277	$ 1,501,651	$ 382,413
Local Environmental Aid	2,145,268	2,200,000	2,200,000	2,200,000	2,200,000	54,732
Nonpoint Source Program	380,648	620,000	620,000	635,500	501,747	121,099
Saline Study for Ogallala Aquifer	–	–	–	–	50,000	50,000
Total - Health and Environment	$ 3,645,154	$ 4,620,000	$ 4,620,000	$ 4,653,777	$ 4,253,398	$ 608,244
Kansas Corporation Commission						
Well Plugging	$ 0	$ 400,000	$ 400,000	$ 400,000	$ 400,000	$ 400,000
Department of Education						
Environmental Education	$ 0	$ 25,000	$ 25,000	$ 25,000	$ 0	$ 0
TOTAL EXPENDITURES	**$ 18,437,879**	**$ 20,971,352**	**$ 20,048,769**	**$ 21,524,537**	**$ 17,819,999**	**$ 1,342,788**

* Removed to reflect major FY 1996 project expenditures which will not occur in FY 1998 .