Approved: April 19, 2007
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Dwayne Umbarger at 10:40 A.M. on March 19, 2007, in Room 123-S of the Capitol.

All members were present except:
Senator Vicki Schmidt- excused
Senator Jean Schodorf- excused
Senator Chris Steineger- excused

Committee staff present:
Jill Wolters, Senior Assistant, Revisor of Statutes
Alan Conroy, Director, Kansas Legislative Research Department
J. G. Scott, Kansas Legislative Research Department
Michele Alishahi, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Michael Steiner, Kansas Legislative Research Department
Amy VanHouse, Kansas Legislative Research Department
Melinda Gaul, Chief of Staff, Senate Ways & Means
Mary Shaw, Committee Assistant

Conferees appearing before the committee:
Chris Tilden, Kansas Department of Health and Environment
Cara Greve, on behalf of Carla Finnell, Executive Director, Kansas Association for Medically Underserved
Patti Spencer, Shawnee County Health Agency
Stephen Albrecht, Regional Director of Governmental Relations, Golden Ventures
Jami Colson, Director, Sales Manager - Kansas, Golden Ventures
John Peterson on behalf of Debra Zehr, Kansas Association of Homes and Services for the Aging
Tom Williams, Asbury Park, Newton
Randall Sipe, Director of Medicaid Research Fundamental Administrative Services, LLC Sparks, MD (written)
Garen Cox, President & CEO, Mediacalodges, Inc., Coffeyville (written)
Cindy Luxem, CEO/President, Kansas Health Care Association (written)
Tom Church, Catholic Care Center (written)
Pam Bachman, Eastridge Skills Center, Centralia (written)

Others attending:
See attached list.

Chairman Umbarger opened the public hearing on:

SB 365--Primary care safety net clinic capital loan guarantee act

Staff briefed the committee on the bill.

The Chairman welcomed the following conferees on the bill:

Chris Tilden, PhD, Director, Office of Local and Rural Health, Kansas Department of Health and Environment, testified as a proponent on the **SB 365** (Attachment 1). Mr. Tilden explained that **SB 365** provides for loan guarantees allowing clinics to borrow for such purposes as purchasing land or buildings, development costs, consultant fees, renovation or new construction, equipment, and "limited working capital during a start-up phase." He noted that the bill authorizes up to $25,000,000 in loan guarantees and they do not know how quickly the clinics will take advantage of the program or amount of funds that might be borrowed.

Cara Cramer-Greve, JD, MHSA, Health Policy Analyst, Kansas Association for the Medically Underserved, spoke in support of **SB 365** (Attachment 2). Ms. Cramer-Greve explained that safety net clinics are facing tremendously escalating requirements for immediate increased capacity to deliver services to vulnerable Kansans in need of care. She explained that the purpose is to promote the availability of long-term, low-cost conventional financing for the development and renovation of safety net primary care clinics, thus allowing primary care clinic capacity to expand and provide more comprehensive care services.

Patti Spencer, Grants and Projects Officer, Shawnee County Health Agency, testified as a proponent on **SB 365** (Attachment 3). Ms. Spencer provided background information on the impact that **SB 365**, the Capital Loan Guarantee Program, would have on the safety net clinics across Kansas. She noted that the existence of this program would result in increased access to services and more providers in the community to meet the needs of the most vulnerable residents.

Rebecca Floyd, Kansas Development Finance Authority, was present and answered questions from the committee. Copies of information were distributed to the Committee regarding the Fundamentals of Municipal Bonds, Kansas Development Finance Authority, Rebecca Floyd, General Counsel (Attachment 4).

Written testimony was submitted by:

Diane Gjerstad, Wichita Public Schools (Attachment 5)
Dave Sanford, Executive Director, GraceMed Health Clinic, Wichita (Attachment 6)
Douglas Stuckey, Chief Financial Officer, Community Health Center of Southeast Kansas (Attachment 7)

There being no further conferees to come before the committee, Chairman Umbarger closed the public hearing on **SB 365**.

Chairman Umbarger opened the public hearing on:

SB 352--Assessments on nursing facilities; quality assurance assessment fund; initiatives for nursing care improvements

Staff briefed the committee on the bill.

The Chairman welcomed Steve Albrecht, Regional Director of Government Relations, Golden Ventures, who testified in support of **SB 352** (Attachment 8). Mr. Albrecht explained that the nursing home provider assessment is a means by which new revenue can be generated to the State of Kansas through additional federal financial participation without requiring the commitment of additional general revenue funds that could impact the state budget. He noted that it would give Kansas an opportunity to address its Medicaid funding gap by passing **SB 352**.

Chairman Umbarger recognized Jami Colson, LPN/DSM, Director of Sales Manager- Kansas, Golden Ventures, who testified in favor of **SB 352** (Attachment 9). Ms. Colson mentioned that with the rising cost in providing services for the elderly in Kansas, passing **SB 352** will give the opportunity to provide the Kansas elderly receiving Medicaid funding with the much needed revenue to provide services.

The Chairman acknowledged John Peterson, who provided testimony on behalf of Debra Zehr, President, Kansas Association of Homes and Services for the Aging, in opposition to **SB 352** (Attachment 10). Mr. Peterson explained that **SB 352** would create a new system that would unfairly target Kansas frail, vulnerable nursing home residents who manage to pay for their own long term care and provided the reasons why in the written testimony.

Chairman Umbarger welcomed Tom Williams, Chief Executive Officer, Asbury Park, Newton, who testified as an opponent on **SB 352** (Attachment 11). Mr. Williams expressed concern regarding starting nursing home bed tax in Kansas. He referred to his experience in Oklahoma where their private pay residents were very upset that they had to pay this extra cost. It also had accelerated the speed of spend-down among private pay nursing residents, creating a larger population of Medicaid recipients in Oklahoma.

MINUTES OF THE Senate Ways and Means Committee at 10:40 A.M. on March 19, 2007, in Room 123-S of the Capitol.

Written testimony was submitted by:

Randall J. Sipe, Director of Medicaid Research, Fundamental Administrative Services, Sparks, Maryland (Attachment 12).

Garen Cox, President and CEO, Medicalodges, Inc., (Attachment 13)

Cindy Luxem, President, Kansas Health Care Association (Attachment 14)

Tom Church, CEO, Catholic Center, Wichita (Attachment 15)

Pam Bachman, Eastridge Skills Center, Centralia (Attachment 16)

There being no further conferees to appear before the committee, the Chairman closed the public hearing on **SB 352**.

Chairman Umbarger turned the committee's attention to discussion of:

SB 338--Kansas state schools for the blind and the deaf, rates of compensation for teachers

A balloon amendment was provided to the committee for discussion by Senator Wysong that would amend the bill to include other professional service providers requiring professional licensure or certification who are paid on the teacher salary scale. KNEA helped in drafting the bill and in forming the definition of teacher. Senator Kelly moved, with a second by Senator Barone, to adopt the balloon amendment on **SB 338** (Attachment 17). Motion carried on a voice vote.

Senator Wysong moved, with a second by Senator Betts, to recommend **SB 338** favorable for passage as amended. Motion carried on a roll call vote.

The meeting adjourned at 12:10 p.m. The next meeting is scheduled for March 20, 2007.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST

Date March 19, 2007

Name	Representing
KEN DANIEL	KSSmallbiz.com
Tom Williams	Ashbury Park
Bill Brady	KASHA
Mary Sloan	KAHSA
Sarah Tidwell	KSNA
Sami Edson	Golden Ventures
Steve Albrecht	Golden Ventures
Cindy Luxem	KHCA
Jennifer Schwartz	KACIL
Deborah Merrill	KHPA
Jennifer Flory	KHPA
Nancy Pierce	KHCA

KANSAS

DEPARTMENT OF HEALTH
AND ENVIRONMENT
Division of Health

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on

Senate Bill 365

Senate Ways and Means Committee

Presented by
Chris Tilden, PhD, Director
Office of Local and Rural Health

March 12, 2007

Chairperson Umbarger and Members of the Committee, I am Chris Tilden, Director of the Office of Local and Rural Health in the Kansas Department of Health and Environment (KDHE). I'm pleased to appear before you today to provide comments on Senate Bill 365, a bill to establish a capital loan guarantee program for primary care safety-net clinics and health centers.

SB365 provides for loan guarantees allowing clinics to borrow for such purposes as purchasing land or buildings, development costs, consultant fees, renovation or new construction, equipment, and "limited working capital during a start-up phase." As we understand it, the bill is intended to support the capacity of safety net clinics to obtain higher loan amounts, lower interest rates, and longer repayment terms for capital expenditures. SB365 requires KDHE to establish a program requiring the agency to guarantee certain loans for clinics and health centers. KDHE currently provides technical and financial assistance to these clinics through the Community-based Primary Care Clinic Grant Program and the Prescription Drug Assistance Grant Program. KDHE has historically been the state agency most involved with the development of network of primary health care clinics and health centers for underserved Kansans.

We have several concerns about the capacity of our program to accomplish the objectives of this bill. None of the current roles, or the functions we perform in the clinic grant program or the charitable health care provider program, equips us to readily administer the provisions of this act with current expertise or staff. As such, it will be our intention to contract with the Kansas Development Finance Authority (KDFA) to assist in the implementation of the proposed bill. The KDFA is currently authorized to issue bonds for healthcare facilities and is increasingly being used as a statewide healthcare resource. Their involvement and experience as a bond issuer in the financial marketplace can serve to provide additional comfort to prospective financial guarantors. We also expect that loan guarantee programs must have requirements for minimum reserve funds for loans that may go into default. We intend to rely upon the KDFA's expertise and experience in this area as well.

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Attachment 1

We would also recommend inclusion of funding for administrative start-up and operational expenses to be incurred by KDHE. The agency has already requested 1.0 FTE program analyst for the primary care clinic program in the SFY 2008 budget. The added agency responsibilities generated by the passage of this act makes the additional position essential. Other expenses would be incurred by Review Committee training, meeting costs, office equipment, and professional fees.

This bill authorizes up to $25,000,000 in loan guarantees. We do not know how quickly the clinics will take advantage of this program or the amount of funds that might be borrowed. It is also unclear to us the source of the initial guarantee fund reserves and how they would be obtained.

Despite these concerns, we strongly support the concept of safety-net clinic loan guarantees. Expanding the capacity of these clinics and health centers is key to insuring that no Kansan goes without needed care. We are confident that the Committee will address the operational issues expressed within our testimony.

Thank you for the opportunity to appear before this Committee. I will be happy to respond to any questions you might have.

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

1129 S Kansas Ave., Suite B Topeka, KS 66612 785-233-8483 Fax 785-233-8403 www.kspca.org

Testimony on:
SB 365- Capital Loan Guarantee for
Primary Care Safety Net Clinics

Presented to:
Senate Ways & Means Committee

By:
Cara Cramer-Greve, JD, MHSA
Health Policy Analyst
Kansas Association for the Medically Underserved

March 19, 2007

For additional information contact:
Kansas Association for the Medically Underserved

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3-19-07
Attachment 2

Senate Ways & Means Committee
March 19, 2007

Good morning Mr. Chairman and Members of the Committee. Thank you for allowing me to appear before you today. My name is Cara Greve; I am the Health Policy Analyst for the Kansas Association for the Medically Underserved. KAMU is an association of primary care safety net clinics. Although Kansas has 34 safety net clinics that serve more than 126,000 Kansans a year, demand exceeds existing clinic and provider capacity and there are geographic areas with no realistic access to a safety net clinic at all. The topic of many recent discussions surrounding health care have centered on the increasing numbers of uninsured individuals due to the backlog in Kansas Medicaid/HealthWave applications. Safety net clinics are facing tremendously escalating requirements for immediate increased capacity to deliver services to vulnerable Kansas in need of care.

Capital Projects Planned:

A number of primary care safety net clinics have capital projects planned, including Topeka, Hutchinson, Pittsburg, Wichita, Independence, Hays and Kansas City, Kansas. Community Health Center of Southeast Kansas in Pittsburg will soon move into a new clinic space. The interest rate on their capital loan could be reduced by 1% through the CLG program. The additional money would be reinvested in patient care. (For a $1M loan, savings of 1% interest could exceed $250,000.)

Purpose:

Promote the availability of long-term, low-cost conventional financing for the development and renovation of safety net primary care clinics, thus allowing primary care clinic capacity to expand and provide more comprehensive care services.

Benefits:

In addition to creating a valuable community service, the program will stimulate economic development opportunities and employment in low-income and rural areas. Benefits for safety net primary care clinics: capacity to obtain higher loan amounts, stronger loan applications, lower interest rates, longer repayment terms and the ability to serve more patients in need. Benefits for lenders: another tool to expand their loan portfolio, improving the economy and quality of life in low income and rural communities and reducing historical concerns surrounding lending funds to non-profit service organizations.

Eligible Entities:

501(c)(3) not-for-profit or publicly-funded community based primary care safety net clinics (Federally Qualified Health Center (FQHC), FQHC-Look Alikes, and indigent clinics) offering a sliding fee discount based upon household income and serving all persons regardless of ability to pay.

Eligible Loans:

Loans eligible for a guarantee under this program must be used for renovation, construction, acquisition, modernization, leasehold improvements and equipping. The program will operate through private-sector lenders who will provide loans guaranteed by the State of Kansas.

Maximum Total Amount of All Loan Guarantees:

$25 million

Maximum Allowable Principle to any single organization:
$3 million

Maximum Term:
Machinery, equipment, renovation, remodeling and leasehold improvements: ten years. New construction and land acquisition: twenty five years.

Loan to Value Ratio:
The loan to value ratio must be at least 66%, thus requiring an equity investment by the organization.

Guarantee by the State:
Guarantee is made by the State of Kansas and as such constitutes a legal, valid, and binding obligation of the guarantor, enforceable against the guarantor.

Eligible tax-exempt bonds or conventional loans may be guaranteed up to 100%.

Review Committee:
A community based primary care safety net clinic guarantee loan Review Committee will be established within the Kansas Department of Health and Environment. The Committee shall consist of five members. At least two Committee members shall have experience in commercial finance from the perspective of a borrower and at least two Committee members shall have experience and expertise in community based primary care clinics.

The Committee shall review all proposals for Kansas community based primary care safety net clinic loan financing guarantees and shall approve those proposals that the Committee deems to represent reasonable risks with a sufficient likelihood of repayment.

While not the complete solution to health care access problems or a substitute for health insurance, safety net clinics have proven to be a cost-effective means of promoting the health of Kansans. The CLG program addresses the need to increase access to health care for our most vulnerable Kansans, while also stimulating development within Kansas communities.

Thank you for your time. We are happy to answer any questions.

Shawnee County
Health Agency
1615 SW 8th Avenue- Topeka, Kansas 66606-1688
Ph. (785) 368-2000 Fax (785) 368-2098

Anne G. Freeze, Director

To: Senate Ways & Means Committee

From: Patti Spencer
Grants & Projects Officer
Shawnee County Health Agency
Main Clinic – Central Topeka, Kansas
Hillcrest Clinic – East Topeka, Kansas
Central Park Clinic – Central Topeka, Kansas

Re: SB 365 - Capital Loan Guarantee Program

Date: March 12, 2007

Mr. Chairman and Members of the Committee:

It is with pleasure and appreciation that I have the opportunity to provide some meaningful background information on the impact SB 365, the Capital Loan Guarantee Program, would have to the safety net clinics across Kansas. In order to continue serving the needs of our patients we must constantly be implementing the most efficient methods while balancing quality, access and program effectiveness.

As the SCHA Grants Administrator I am involved in securing funding for ongoing operations and future program/capacity development. In order to continue serving the needs of our current users, now more than 25% of the over 27,000 uninsured/under insured in Shawnee County, we must constantly be implementing the most efficient methods while balancing quality and access to keep our service's effectiveness. 51% of our total FQHC users are uninsured (UDS 2006 data).

In 2006 we implemented new 340b Prescription Assistance services and expanded our previously minimal mental health services now providing fully integrated primary care and mental health treatment to serve 40% more patients in just the first year. In mid-2006 SCHA commissioned a thorough evaluation of our Community Health Center organizational structure and operations. The primary purpose was to see if there were any other immediate options for expanding users and providers.

The consultants we hired were highly skilled and had worked with FQHCs from all over the country. The results of the study concluded there were few things we could do to expand services, providers and ultimately serve more of the uninsured except to develop new facility space. *Since our existing 3 sites are pushed to their special capacities, that means finding or creating a new building.*

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Attachment 3

What would the existence of the Capital Loan Guarantee Program mean to SCHA?

It would provide the foundation for building support for a Capital Project Campaign. Having a portion of the funding in place and guaranteed prior to seeking support from individual donors, private foundations and local government sponsors would be a huge benefit to our agency's fund raising efforts. It would shorten the amount of staff and Board member time/energy spent convincing potential supporters of the project's legitimacy. ***It would result in increased access to services and more providers in our community to meet the needs of the most vulnerable residents.***

The plan **does not** provide grants or gift dollars nor does it use state funds to directly lend to clinics for construction. It **does** provide a maximum of $3 million to individual clinics for a total of $25 million for all projects. The Loan to Asset Value Ration is 66% so equity is required to solidify community investment and provide a budgeted cushion. Loans would be used for renovation, construction, acquisition, modernization and/or equipment.

Very soon, all federally funded clinics will be required to have in place an Electronic Health Record (EHR) system for which there are no grant federal funds, currently, available to purchase. This program, for that reason alone, would provide the needed "purchase over time" option clinics need to be able to obtain the hardware, training and installation services that would be a financial burden for many if forced to fund the purchase during a single budget year. Purchases for software would not be included as a Capital Loan project request.

Adding just one new provider would allow a clinic to serve hundreds of new patients per year. Purchasing and installing EHR will increase the efficiency of our support staff and provide, ultimately, better access and quality of care to our patients. The establishment of the Capital Loan Guarantee Program would allow safety net clinics to accomplish those goals quickly and successfully as they struggle to continue to meet the challenges we have now and work to plan for the needs we know will grow in the years to come.

I ask for your support of SB 365 as a tool to Kansas' safety net primary care clinics to meet the growing uninsured and under insured medical needs of those who live and work in our state.

Respectfully submitted,

Patti Spencer

Patti Spencer

Fundamentals of Municipal Bonds

Kansas Development Finance Authority
Rebecca Floyd, General Counsel

I. Municipal Bonds

A. Basics

Bond Definition: a bond is a financial instrument backed by a contractual agreement between an issuer and an investor. The issuer of the bond agrees by contract to repay principal and interest to the owner of the bond over a period of time (typically 15-25 years).

1. Use: municipal bonds are issued by state and local governments or by their political subdivisions such as authorities and special districts to fund infrastructure and capital projects needs. The distinguishing feature of state and local municipal bonds is that the interest income on municipal bonds is exempt from federal income taxes—i.e., a subsidy of the federal government to allow state/local governments a way to affordably finance their capital programs (§103(a) of the Internal Revenue Code ["IRC"]). The tax-exempt feature of municipal bonds makes them attractive to individuals and other buyers in higher marginal tax brackets. The tax exemption enables state and local governments to borrow from the capital markets at significantly lower interest rates than those prevailing in the taxable markets such as the corporate bond market. (example: current tax-exempt rates as of 02/2003 are in the 3-5% range)

2. **Debt Service**: Debt service refers to the, usually, semi-annual payments of principal and interest on the bonds. The debt service is comprised of an underlying revenue stream, dependent on what type of bonds are issued e.g. revenues from a parking garage or dormitory are pledged as debt service, or a tax-levy may be pledged if general obligation bonds are issued.

3. **Tax-Exemption**: In order to qualify as a tax-exempt bond, the issuer and the purpose of the bond issue must meet certain requirements i.e. the issuer must be a governmental entity and the bonds must be issued for a governmental purpose. The objective of the issuer (e.g., KDFA) is to raise capital at the lowest cost.

4. **Issuer**: KDFA was created by the 1987 Kansas legislature to operate as a statewide multipurpose finance authority. KDFA was created for the purposes of enhancing the ability of state agencies, political subdivisions, and other public and private sector entities to access the capital markets with the goal of raising capital at the lowest possible cost. KDFA is the most active issuer of municipal and private activity bonds in the State of Kansas, and is recognized nationwide as a

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sophisticated issuer whose paper is in demand and garners extremely competitive rates.

Other issuers include local governmental units such as cities and counties.

B. Governmental & Private Activity Bonds

1. The Tax Reform Act of 1986 distinguishes between 2 types of municipal bonds:

(a) **Governmental Bonds**: Bonds issued the proceeds of which are used for qualified governmental/public purposes. These bonds are tax-exempt and typically generically called municipal bonds. The 2 basic categories of municipal bonds are:

- **General Obligation**: Bonds backed by the full faith and credit of an issuer with taxing power. The State of Kansas is generally prohibited by the Kansas Consititution from issuing GO debt, with some minor exceptions.
- **Revenue Bonds**: Bonds backed by an underlying revenue stream usually directly related to the project, e.g., lease payments, revenues generated by the facility financed (hospital revenues, utility revenues, rental revenues, parking revenues, tobacco settlement receipts,etc). All the bonds issued by KDFA on behalf of the State are revenue bonds.

Project Examples: hospitals, highways, schools, bridges, sewers, jails, parks, government buildings and equipment, etc.) Private entities may not significantly use, control or own the facilities financed. Governmental bonds benefit the general public in contrast to Private Activity Bonds which benefit private persons/activities.

(b) **Private Activity Bonds** ("PABs"): Bonds issued the proceeds of which are used to benefit private persons or activities. These bonds fail three tests for tax-exemption: Either the (1) The Private Business Use Test; and (2)The Private Security or Payment Test or (3)The Private Financing Test. These bonds are taxable, unless they are issued as qualified private activity bonds meaning the proceeds are used for projects and activities that may have private characteristics, but are nevertheless deemed to be eligible for tax-exempt bond financing.

Private Business Use Test: In general, the private business use test is met if private business use of a facility financed with bonds exceeds 10% of the proceeds of the issue. Private business means users other than a state or local governmental unit, including the federal government.

Private Security or Payment Test: The private security or payment test is met if more than 10% of the payment of principal and interest on a bond is directly or indirectly secured by property used in a trade or business, or derived from payments related to property used in a trade or business, whether or not such property is financed with the proceeds of tax-exempt bonds.

Private Financing Test: Bonds become private activity bonds and lose their tax-exemption, unless they are qualified private activity bonds, if more than the lesser of 5% or 5 million of the proceeds are used to make loans to nongovernmental persons.

Project Examples of Qualified (tax-exempt) Private Activity Bonds: (1) exempt facility bonds: airports; docks & wharves; mass-commuting facilities; water & sewage facilities; solid waste disposal facilities; qualified residential rental projects; utilities.;(2) Qualified mortgage bonds – Multi-family mortgage revenue bonds for people of low & moderate income, and the single –family mortgage revenue bond program that makes available below-market interest rate mortgages to first-time home buyers. Kansas is now the only state in the country who does not have a statewide single family mortgage bond program.; (3) Qualified Redevelopment Bonds and Enterprise Zone bonds. Infrastructure projects which involved redevelopment of blighted areas, enterprise zones, etc. (4) Qualified 501(c)(3) Bonds: "qualified hospital bonds" and "qualified non-hospital bonds".
(5) Qualified Exempt Small Issues: Bonds issued for qualified manufacturing projects and the Beginning Farmer program. (6) Qualified Student Loan Bonds.

C. Arbitrage Rebate Requirements

1. **Arbitrage Bond** defined: An arbitrage bond is any bond issued as part of an issue any portion of the proceeds of which are reasonably expected (at the time of the issuance of the bond) to be used directly or indirectly to acquire higher yielding investments or replace funds which were used directly or indirectly to acquire higher yielding investments. (§ 148 (a) IRC)
   Translation: the general rule is that bond proceeds may not be invested at a yield higher than the yield borne by the bonds. If the investment earnings rate is higher, then that spread or "arbitrage" must be rebated back to the federal government. To avoid arbitrage and possible associated penalties, bond proceeds which will not be expended immediately are invested in "Guaranteed Investment Contracts" in yield restricted investments. Also, in order to maintain the tax-exempt status of tax-exempt bonds, proceeds must be invested in other tax-exempt obligations. Conversely, the proceeds of taxable bonds are not subject to arbitrage restrictions, and may be invested in taxable obligations.

2. Exceptions to Arbitrage Rebate requirements:

   (a). Bonafide Debt Service Funds: Excluded from the rebate computation during a bond year are investment earnings on bonafide debt service funds to the extent such earnings are less than $100,000 during such bond year. This test is deemed satisfied to the extent the average annual debt service does not exceed $2.5 million.

   (b). Spending Exceptions to Rebate—6 month exception: an issue is treated as meeting the rebate requirement if the gross proceeds of a bond issue are allocated to expenditures for the governmental purpose of the bond issue within 6 months of the issuance date.

   18 month exception: An issue is treated as meeting the 18 month exception if all at least 15 % of the proceeds are spent within 6 months of the issuance date; 60 % of the proceeds are spent within 12 months; and 100 % within 18 months.

D. Hedge Bond Prohibition

1. A bond will not be tax-exempt if it is a Hedge Bond. Hedge Bonds are bonds issued to "lock-in" a perceived low interest cost when proceeds are not actually needed for their intended governmental purpose. The Hedge Bond rules are separate and in addition to rules governing PABs, arbitrage, and rebate.

2. A bond is a hedge bond unless:

- The issuer reasonably expects, on the date of issuance, at least 85% of the issuer's spendable proceeds will be used within 3 years to carry out the governmental purpose of the issuance; and
- Not more than 50% of the proceeds are invested on nonpurpose investments having a yield that is substantially guaranteed for 4 or more years.

II. KDFA & Finance Transaction Basics

A. KDFA

1. KDFA was created by the Kansas Legislature pursuant to (K.S.A. 74-8901 et seq., as a state-wide multipurpose issuer to assist State entities and other public and private enterprises throughout the state access the long term capital markets at the lowest possible cost.

2. KDFA is the most active issuer in the state of Kansas, averaging 12-25 debt issues a year, including notes, bonds, leases, and other certificates of indebtedness. KDFA is recognized as a sophisticated conduit issuer, whose debt is widely sought by institutional and retail market investors resulting in extremely competitive pricing advantages to borrowers.

3. KDFA assists borrowers by serving as an "in-house" financial advisor, will work closely with the borrower's own banker and finance team, or at the request of a borrower, will assist the borrower in its selection of a finance team.

4. KDFA works closely with the borrower and finance team professionals to develop the appropriate finance structure and marketing strategies for a particular debt issue, assists in identifying the necessary disclosure issues, and serves as an ongoing guide and resource to the borrower as the borrower deals with long-term post-issuance compliance responsibilities.

5. Amendments to the KDFA Act in 2004, expanded the Authority's issuing authorization to allow KDFA to issue bonds for county hospitals also for the first time.

B. Finance Transaction Basics

1. The finance team for a bond transaction generally includes the following principal participants: Borrower, Conduit Issuer (e.g., KDFA or another governmental entity) Bond Counsel, Trustee and an Underwriter/Investment Banker.

   Issuer: This is the governmental entity that is borrowing money by issuing bonds. The federal tax laws require that the issuer be a state or political subdivision, including municipal entities, independent instrumentalities and authorities on behalf of a state or political subdivision.

   Borrower: In conduit revenue bond financings, the issuer issues the bonds not for its own use, but to re-lend the bond proceeds to a private party which uses the bond proceeds to finance, e.g. an affordable housing project, hospital, manufacturing project, educational or government facility, etc.

   Bond Counsel: Bond counsel is a law firm with nationally recognized expertise with respect to municipal bond transactions. Investors will not buy tax-exempt municipal bonds unless there is an opinion of a recognized law firm to the effect that the bonds are validly issued and the interest on the bonds is tax-exempt. Bond counsel must be experienced with all aspects of structuring a tax-exempt or taxable financing, and has duty to advise the issuer and underwriter on all legal aspects of the bond issue.

   Underwriter (Investment Banker): The underwriter is an investment banking organization whose business is to help structure bond issues and purchase and resell the bond issues on behalf of the issuer. Underwriters are subject to the jurisdiction of the Securities and Exchange Commission, and underwriters of municipal bonds are also governed by the federal Municipal Securities Rulemaking Board.

   Bond transactions will often include the following additional parties:

   Credit Enhancer: This is a third party which is providing the credit support for the bond issue upon which the investors are primarily relying. A credit enhancer might be an insurance company which may insure an entire bond issue (e.g., MBIA, AMBAC) a mortgage insurer (e.g. FHA), a bank which issues a letter of credit that effectively guarantees the bond or the mortgage, or a guarantor such as FNMA or GNMA.

Rating Agencies: The rating agencies are nationally recognized organizations which rate the credit worthiness of bonds. The two primary rating agencies are Standard & Poor's Ratings Services, and Moody's Investor's Services. Fitch is a third nationally recognized rating agency. For a fee, the rating agencies assign various types of credit worthiness ratings to bond issues. Investors and even underwriters, tend to rely upon the ratings provided by these organizations in assessing the credit quality of the bonds, and investors rely on them to determine the resulting interest rate the investors will require to purchase the bonds.

Mortgage Banker: FHA, FNMA, FHLMC and GNMA financings usually involve a mortgage banker, whose role is to handle the mortgage origination process and service the mortgage.

2. The Bond Transcript is generally comprised of the following basic documents:

Trust Indenture: The agreement between the Issuer and the bank serving as Bond Trustee This document sets forth all of the important terms, provisions, and covenants which establish the parameters for the bonds and provide certain assurances of payment and protections to the bondholders.

Financing Agreement: The agreement between the Issuer and the Borrower. It may be a Loan Agreement, Lease-Purchase Agreement, or just a Promissory Note and Mortgage. The Financing Agreement includes the terms and provisions for the loan of the bond proceeds, the Borrower's agreement to repay the loan in amounts and at times sufficient to enable the Issuer to repay the bonds; security for the Borrower's repayment, and other project specific information.

Bond Purchase Agreement: This is the agreement between the Issuer and the Underwriter, setting forth the terms and conditions under which the Issuer agrees to sell the bonds to the Underwriter, and the Underwriter agrees to purchase the bonds from the Issuer.

Official Statement: The Official Statement is dated the date the bonds are sold and contains the final terms of the bonds. Under federal securities laws, the Issuer and the Borrower are obligated to disclose in this document and the predicate **Preliminary Official Statement ("POS")** all information that a "reasonable investor" would consider material in deciding whether to purchase a bond. The POS which is distinguished by the use of "red herring" language

on the cover, is complete except for interest rates and maturities. Once sold, these items are completed and the final Official Statement is circulated.

Bonds: The bonds are interest bearing promises to pay a specified sum of money on a specific date to the bondholder. The form of the bonds is contained in the Indenture.

Continuing Disclosure Agreement: The agreement wherein the Issuer and the Borrower agree to provide ongoing disclosure of various financial and other information as required by Ruler 15c2-12.

Investment Agreement: Also sometimes referred to as the Guaranteed Investment Contract or "GIC", this is the agreement between the Issuer and a financial institution in which bond proceeds are invested at a fixed rate and term, subject to withdrawal at various times, per the terms of the agreement.

Regulatory Agreement: Also referred to as a land use agreement, used in rental housing conduit issues, this is an agreement executed by the Borrower and recorded with the mortgage to ensure compliance with federal tax law requirements, principally addressing the income limits for tenants.

Arbitrage or Tax Compliance Certificate: The Arbitrage Certificate is executed to establish, for federal tax purposes, the Issuer's reasonable expectations surrounding the issuance of the bonds at the time of their issuance.

Legal Opinions: The opinion of Bond Counsel regarding the tax-exempt (or taxable) status of interest on the bonds. The opinion also states that the bonds are legal and binding obligations of the Issuer, and the source of payment or security for the bonds. Opinions are also typically delivered by the Underwriter's Counsel and the Issuer's Counsel or General Counsel.

Senate Ways and Means
Senator Umbarger, chair
S. B. 365 Primary care safety net clinic loan program

March 12, 2007
Diane Gjerstad
Wichita Public Schools

Mr. Chairman and members of the committee:

The Wichita Public Schools rises in support of S.B. 365 which creates a loan guarantee program for safety net clinics. We believe a project we are beginning illustrates the need.

Wichita's Board of Education has authorized the construction of a new K-8 school at 21st and Opportunity Way. This complex is located in northeast Wichita, just west of the Wichita State University campus, in a "Family and Children Empowerment Addition" designated by the City of Wichita. The school district has a school based clinic operated at Lincoln Elementary for over ten years. The Lincoln site has served over 46,000 low-income children. Over 4226 were served in calendar 2006. A dental program added in 2006 has served over 1600 children.

The partnership with GraceMed has a tremendously positive track record for our students and their families. The "new school" is an opportunity to expand this partnership. Attached to my testimony you will find the site map outlining the layout. The Board plans to authorize construction in early April. Because the district is governed by the cash basis law, the District must have the entire cost of construction in the bank, including the portion to fund construction of the clinic of about $490,000.

GraceMed has launched a fund raising campaign which we are confident will be successful. However, it is both parties best interest to construct both the school and the clinic simultaneously. In order to build the project as one, the Board must bank the $490,000, too. This will tie up one-half million of the District's capital outlay for two years. This is step our Board takes with cautiously and quite frankly many organizations would not have the same capability. This is why, in our opinion, this loan guarantee program is good policy.

Passage of S.B. 365 would expand partnerships such as we are forging in Wichita. We would suggest the bill become effective on publication in the Register and it would be extremely helpful if the establishment of the act could be expedited to assist our project.

Thank you, Mr. Chairman.

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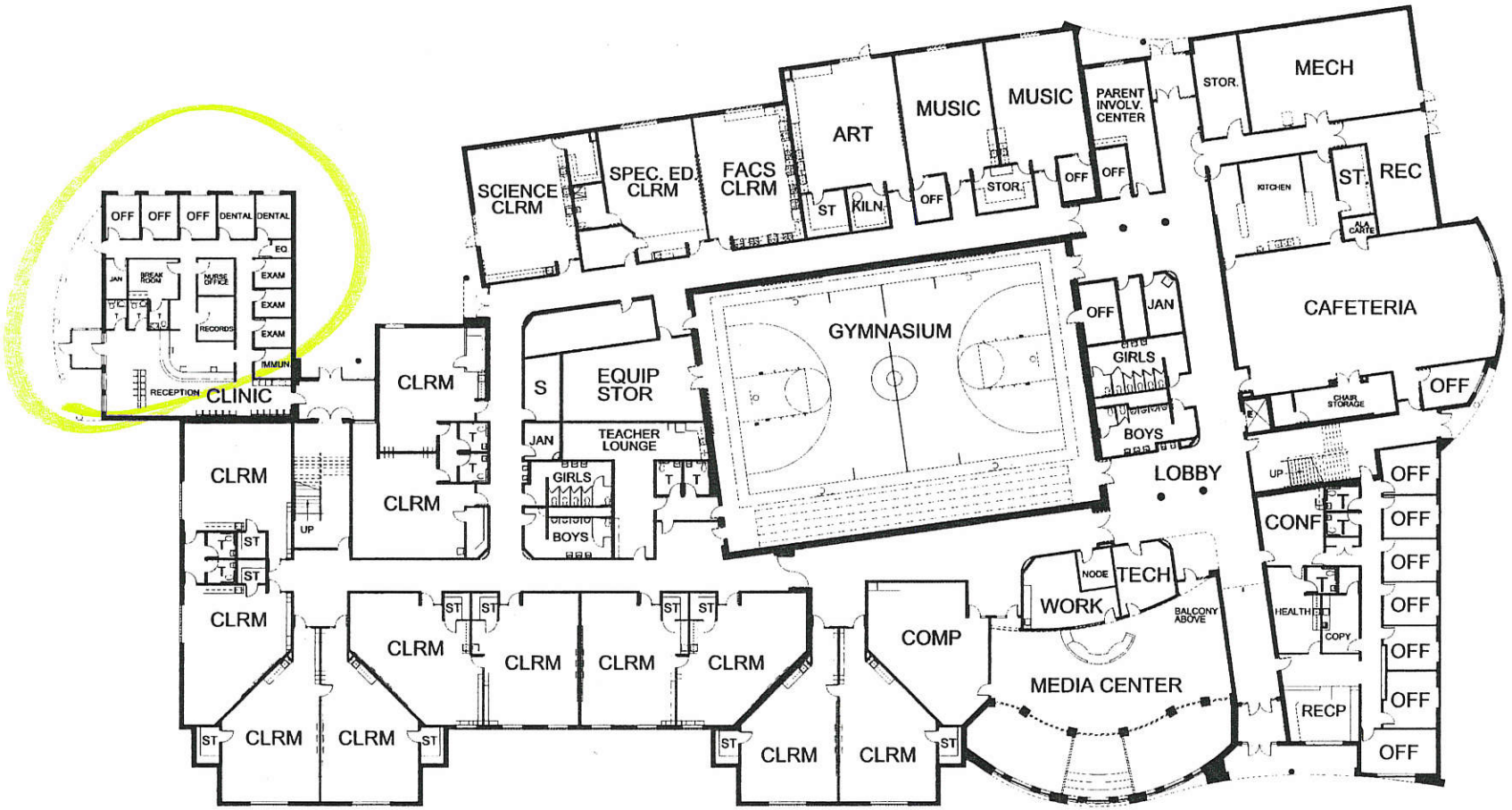
WICHITA PUBLIC SCHOOLS

Earhart Environmental Magnet Elementary & 25th Street K-8 Schools



25th Street K-8 Main Level

GraceMed
A Health Ministry of the United Methodist Church
Kansas West Conference

Corporate Office
Phone - 316.866.2000 1122 N. Topeka- Wichita, KS 67214 Fax - 316.866.2083

March 12, 2007

Mr. Chairman and Distinguished Members of the Ways & Means Committee:

My name is Dave Sanford and I am the Executive Director of GraceMed Health Clinic, Inc. in Wichita. GraceMed was established in 1979 as a Christian health care ministry and is affiliated with the United Methodist Church Kansas West Conference. We are also the only Federally Qualified Health Center Look Alike (FQHC-LA) in Kansas. This designation allows GraceMed to receive reimbursement for medical and dental care provided for Medicare, Medicaid and HealthWave-eligible residents. However, the majority of our patients are uninsured (53% in 2006).

I respectfully encourage you to consider and approve SB 365, the Capital Loan Guarantee Bill, to promote the availability of long-term, low-cost conventional financing for the development and renovation of safety net primary care clinics, like GraceMed.

In the fall of 2004, GraceMed met with Via Christi Regional Medical Center representatives to identify potential sites for clinic expansion. We were very fortunate to find a Via Christi-owned building on the campus of St. Francis Hospital, in mid-town Wichita. Over the next year, GraceMed raised $450,000 in private funds to remodel this larger facility and relocate our main medical and dental clinics to the site.

In January of 2006, GraceMed finally relocated to this larger facility. In so doing, we significantly increased access to quality health care for uninsured and underinsured residents of South Central Kansas. For comparison, in 2005, GraceMed recorded 20,652 patient visits to our dental and medical clinics. With this larger facility, GraceMed provided care through 30,083 patient visits in 2006, an increase of 46%!

GraceMed is blessed that the greater Wichita community, through private donations and foundation grants, supported the cost of our remodeling project. However, it did take over a year to raise all the funds necessary to accomplish our goal. If a **Capital Loan Guarantee** program had been in place, the remodeling could have started by January of 2005. And, our ability to increase access to quality health care for residents of South Central Kansas could have been moved up six months.

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Currently, GraceMed is faced with overwhelming demand for quality medical and dental services. We have a six-week waiting period for non-emergency dental care and a two-week waiting period for non-emergency medical care. To address this demand, we are currently:

- Adding four more dental operatories at our main clinic (for a total of ten). We waited until we had private funds to start this project.
- Raising funds to add nine additional medical exam rooms at our main clinic. This will allow GraceMed to hire three additional medical providers and provide care through another 11,200 patient visits per year.
- Raising funds to remodel our satellite clinic dental operatories so that we can provide both restorative dental care and hygiene services at these pediatric two clinics.

In addition to these projects, we have a wonderful opportunity with USD 259 to open a third pediatric satellite clinic as part of a new K-8 school to be built by the fall of 2008 in a low-income area of northeast Wichita. This clinic will also be close to a new Boy's & Girl's Club facility and The Opportunity Project, a pre-K education center for 200 children. We have begun to raise funds ($490,000) for this project, yet would have benefited from a **Capital Loan Guarantee** program.

Obviously, the **Capital Loan Guarantee** program does not allow GraceMed or any other safety net clinic to abdicate its responsibility to raise funds for capital projects. However, this program would allow GraceMed and others to proceed with plans to add facilities to increase access to quality health care while providing a longer period of time to raise funds and cover project costs.

In Sedgwick County, there are over 55,000 uninsured residents. Our best estimate is that half receive care from one of five safety net clinics in the area. Many residents use hospital emergency departments for primary care. If agencies like GraceMed can increase access to care for area residents, not only will health outcomes improve, but the cost of providing care will be reduced. Community Health Centers throughout the country have proven to be the right option to achieve these desired results.

Approving the **Capital Loan Guarantee** bill is an opportunity to strengthen the safety net system in the State of Kansas.

Kind regards,

David C. Sanford

David C. Sanford
Executive Director
GraceMed Health Clinic, Inc

Community Health Center of Southeast Kansas

March 12, 2007

Senate Ways & Means Committee

Mr. Chairman & Members of the Committee:

My name is Douglas Stuckey, Chief Financial Officer of Community Health Center of Southeast Kansas (CHC/SEK), located in Pittsburg. I appreciate this opportunity to provide written testimony in support of the capital loan guarantee bill and how it could impact our organization and other primary care clinics in Kansas.

CHC/SEK is a Federal Qualified Health Center (FQHC) that was founded in May of 2003 with a mission to provide high-quality, culturally-appropriate and cost-effective health care to all individuals regardless of their ability to pay. We are the only provider of comprehensive primary care to the medically underserved in the nine-county region.

Our clinics provide a broad range of services including primary care, obstetrics, pediatrics, dental and behavioral health at seven locations in two counties. In the past year, we cared for 9,310 patients from 26 Kansas counties for a total 29,940 visits; 85% of our patients are either low-income and uninsured or recipients of public health insurance benefits. All services are offered on a sliding scale relative to income.

Between calendar years 2005 and 2006, CHC/SEK saw a 72% increase in patient visits. Even with its primary medical clinic open 50 hours per week, however, CHC/SEK reached physical capacity in 2005. Over one-third of patient visits take place in a hopelessly inadequate 1,500 square foot modular building,

To address our facility needs, we initially tried to pursue a $400,000 community development block grant but failed because we could not secure an adequate bank commitment for the project. We were told CHC/SEK did not have enough financial history at the time, funding was too complex and the fact that we were a non-profit was detrimental in their analysis. A USDA loan guarantee was then investigated and started, but I estimated it would take more than two years to complete the loan application process alone, and we simply could not wait that long.

A capital loan guarantee at *that* time would have provided the State's validation of its primary care clinics, giving any potential lender the added confidence to finance a project that would not necessarily meet their more-strict commercial lending guidelines, even though CHCs are very sustainable given their cost-based reimbursement formula and consistent federal/state funding growth over the FQHC's thirty year history.
Discouraged but not defeated, CHC/SEK began a campaign in July 2006 to raise funds for a new clinic that would offer primary care, mental health, dental and pharmacy services under one roof,

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consolidating four sites into one efficient space. To date, we have raised $1,000,000 of the approximately $2,000,000 project cost. One hundred percent of this money was raised in Crawford County, a county with one of the lowest per-capita incomes in Kansas. The balance of the construction will be funded by a consortium of three community-minded banks.

Today, Community Health Center of Southeast Kansas remains in that 1,500 square foot modular building. *Only* because of the generous support of our community and bankers who personally believe in our management and mission, we are moving into a 15,000 square foot facility next month. Our story is the exception, however, as most primary care clinics cannot garner this kind of community support because of the population we serve.

The State's imprimatur is vital to expanding primary care facilities, which ultimately reduces overall Medicaid costs by providing cost-effective care that will inevitably reduce emergency room visits.

It is my belief that a capital loan guarantee program would also provide a legislative "seal of approval" that would allow us to seek competitive financing rates, and not rely on the dwindling supply of truly-committed, community-minded bank officers. For every reduced interest rate point, CHC/SEK would save nearly $250,000 in interest costs over the term of the loan, money which would be reinvested into patient care.

I believe the capital loan guarantee program would not cost the state one cent, assuming proper due diligence, and actually save the State in overall Medicaid payments by providing cost-efficient primary care to those who need it the most. **Therefore, we support SB 365 and urge the Committee to do the same.**

Thank you for your time.

Douglas Stuckey, Chief Financial Officer
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golden
ventures

Testimony
Senate Ways and Means Committee
Steve Albrecht, Regional Director of Government Relations, Golden Ventures
March 19, 2007

Mr. Chairman and members of the Ways and Means Committee, my name is Steve Albrecht, Regional Director of Government Relations for Golden Ventures and I am submitting testimony today in support of Senate Bill 352. Golden Ventures is a long-term care provide operating 18 Golden Living Centers in Kansas, employing approximately 1,000 people and proudly caring for 950 frail and elderly Kansas each and every day.

Golden Ventures operates some 350 nursing homes and assisted living facilities in 24 states and we are well aware of the many challenges facing legislatures across the country as they strive to address the needs and costs of Medicaid. In particular, nursing homes are seen as a major cause of increased Medicaid costs. But in reality, nursing home costs in many states have been growing significantly less than overall Medicaid costs due in part to rate reductions, rate freezes, or utilization of outdated cost reports that fail to accurately reflect the true and total cost of care.

Yet in Kansas, as in many other states, nursing home rates continue to see a widening gap between the cost of caring for residents in their nursing facilities and the rate they are paid by Medicaid. According to a recent study prepared by BDO Seidman, the shortfall in funding between the cost of care and rates paid in Kansas is $45 million (almost $12 per Medicaid patient day). This widening gap has been worsened by Medicare cuts, which took effect January 1, while the federal government asks states to help pay for the Medicare Part D program as well.

In Kansas you have an opportunity to address your Medicaid funding gap by passing SB 352. The nursing home provider assessment is a means by which new revenue can be generated to the state of Kansas through additional federal financial participation without requiring the commitment of additional general revenue funds that could impact the state budget. Golden Ventures has seen assessments such as this work in other states, most recently in Indiana. Indiana's provider assessment has afforded Golden Ventures the opportunity to increase wages of employees and pursue capital improvements that are having a direct impact on the overall quality of life for our residents. And, the U.S. Congress recognized the importance and legitimacy of this type of funding policy when it passed bipartisan legislation late last year that places this policy in statute.

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

At Golden Ventures we believe the provider assessment in SB 352 will address funding needs not only specific to nursing homes but it can also assist Kansas Medicaid in supporting other necessary programs across the entire long-term care continuum.

On behalf of our residents and our employees I strongly urge you to vote in favor of SB 352.

Thank you for your time and consideration.

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Mr. Chairman and members of the Ways and Means Committee, my name is Jami Colson, I am a licensed practical nurse, working as a DSM for Golden Ventures, representing 18 Golden Living Centers in Kansas, and I am her today to speak in support of Passing the Senate Bill 352.

I have the opportunity to work in a field everyday where Making and Difference is possible. With the rising cost in providing services for our elderly in Kansas, Passing the Senate Bill 352 will also give you the opportunity to provide our Kansas elderly receiving Medicaid funding with the much needed revenue to provide services.

It is more difficult everyday for the LTC to absorb the rising cost of healthcare. It is no secret that the cost for healthcare is changing. This is due largely to the higher cost of healthcare services in general, higher acuity levels of those residents in the hospital requiring Long term care placement. On a regular basis the hospitals will ask you to take on the care of a resident with multiple clinical issues such as, feeding tubes, air mattresses, wound vac's, multiple dressings for wounds, transportation for dialysis patients, infectious diseases requiring isolation and all of these complex residents will also require multiple medications and quality personal to provide care. The current reimbursement rates do not cover the daily costs for our residents.

By Passing Senate Bill 352 By increasing the funding to the facilities ~~it while~~ decreasing the length of stay at the hospital level. Passing on much needed relief to the hospitals that incur a higher cost when finding placement for a high acuity resident is difficult.

Passing Senate Bill 352 could also assist the facilities in Kansas in other great ways such as providing staff with increase in salaries allowing us to be more competitive in the work force, providing education and advanced training to the exceptional group of individuals already making a difference everyday in the life of our elders. This bill can open up opportunities for the facilities to increase their Activity programs, Dinning services, and much needed renovation in the rural markets.

I would like to thank you for the chance to speak with you on this issue. At Golden Ventures we believe by Passing Senate Bill 352 it will help support our Kansas Medicaid precipitants. Again by increasing the funding, the facilities will be able to pass on the benefits through wonderful programs, safe environments, and well-trained personnel, all while increasing the quality of life for our elders. Together we can all make a difference everyday in a life of a Kansan.

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KAHSA
creating the future of aging services

Debra H. Zehr, President
Kansas Association of Homes and Services for the Aging
To the Senate Ways and Means Committee
March 19, 2007

Testimony in Opposition to Senate Bill 352

Thank you, Chairman Umbarger and Members of the Committee.

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

We oppose Senate Bill 352, which would constitute a major, misdirected policy change.

Senate Bill 352 would create a new system that unfairly targets Kansas frail, vulnerable nursing home residents who manage to pay for their own long term care. Here's why:

Business taxes are essentially costs of doing business and, like other costs, tend to be passed on to customers through the price of products or services. Nursing home provider taxes are no exception. What is somewhat unique about nursing home provider taxes is that the state acts both as tax collector and third-party payer for services on behalf of Medicaid residents. The problem is that, although about 43% of a Kansas provider tax will be levied on private pay residents, repayment will occur only through the Medicaid rates. As a result, private pay rates will increase by an amount sufficient to cover the cost of the tax. Clearly, private pay residents will bear much of the burden of the proposed provider tax. According to our national experts on this topic, the direct cost of the tax to private pay residents could total more than $9 million annually.

By federal law, the gains from the tax will not be distributed uniformly among all nursing homes, and there can be no guarantee that homes will be held harmless. Many will receive nothing in return for the tax and others will receive less in increased Medicaid revenues than the cost of the tax. According to our national experts over 40 nursing homes will suffer annual losses totaling some $1.2 million.

Even if the tax was set up and administered so that most providers received rate increases initially, the experience of other states is that the tax goes up and the benefit to the nursing home and its residents goes down over time.

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The President has been very public about his distaste for the provider tax, calling it a loophole that allows for cost-shifting. Many in Congress agree with him. Senator Tom Coburn, M.D., R-Oklahoma, recently stated, "...CMS has got to put an end to these schemes based on Medicaid's perverse incentive structure." In fact, the 2006 Congress ratcheted down the maximum tax that can be assessed and the Office of the Inspector General has turned more attention to scrutinizing provider tax programs that are in use today. It would be unwise for Kansas to become dependent on this mechanism for boosting Medicaid dollars, as have some states, only to have it pulled out from under us in the future... or even made to pay it back.

Finally, as you may recall, a similar bill was introduced in the House last year. It was hotly debated and in the end the Committee decided to take no action. Nothing has changed since that time. Major stakeholders still do not agree. There has been virtually no conversation about it.

With all of this in mind, KAHSA asks this Committee to consider all of these red flags and to oppose Senate Bill 352.

Thank you.

Asbury PARK

March 16, 2007

To The Kansas Senate Ways and Means Committee
Committee Chair Senator Dwayne Umbarger and Members of the Committee:

My name is Tom Williams. I am the Chief Executive Officer for Asbury Park, a not-for-profit retirement community in Newton, KS, affiliated with the United Methodist Church. We have 73 nursing residents, 55 assisted living residents and over 100 elders living in our cottages.

The "nursing home bed tax" started in Oklahoma in 2000. I was able to see first-hand how it worked and experience its impacts while I was a nursing home administrator in that state from 2001 to 2005.

Our private pay residents were very upset that they had to pay this extra cost. It has also accelerated the speed of spend-down among private pay nursing residents, creating a larger population of Medicaid recipients in Oklahoma.

Many of my colleagues in health care administration in Oklahoma who originally were supporters of the bed tax now want it to go away because:

1. The tax rate has increased.
2. Medicaid reimbursement rates aren't keeping pace with the tax. In fact, my colleagues that I have visited with about the bed tax haven't received any Medicaid rate increase in at least the last three years.
3. Residents and their families are becoming more irate about it every year.
4. It requires more paperwork that isn't justified by the return.

The overall general consensus is that what they thought would help their financial position has instead interfered with their ability to operate competitively and retain staff.

It is evident just south of our state border that this type of tax burdens long term care providers and residents, and adds another layer of bureaucracy to the second most regulated business in the world.

Two of the reasons I returned to Kansas are because of the higher standards for care and the respect for the frail elderly in this state. I ask you to question the wisdom of starting a bed tax in Kansas. I ask you to oppose Senate Bill 352.

Thank you.

Tom

Tom Williams
Asbury Park CEO

Voice: 316-283-4770
Fax: 316-283-4799

Asbury Park is a Ministry of the United Methodist Church
www.asbury-park.org

200 Southwest 14th Street
Newton, KS 67114

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FUNDAMENTAL™

March 14, 2007

Mr. Chairman, and Committee Members,

Subject: Support for the Kansas Nursing Facility Quality Assurance Assessment Bill, (Senate Bill No. 352)

My name is Randall J. Sipe. I am the corporate Director of Medicaid Research for Fundamental Administrative Services. Fundamental is a premiere provider of Skilled Nursing Facility Services, Assisted Living Services, and Long Term Acute Care Hospital Services in the state of Kansas. We also provide these long term care services in 16 other states as well as provide hospice, inpatient rehabilitation and outpatient clinic services.

I am proud to say that we currently employ 393 hard working dedicated and caring employees in our 5 Kansas skilled nursing centers.

We are very proud of the quality skilled nursing facility services that our dedicated staff provide to the residents in the Kansas communities of Topeka, Overland Park, and Hutchinson.

The average daily number of residents in our 5 skilled nursing care facilities varies, but recently is approximately 363. Of those residents, approximately 250 or 69% have their care paid for by the Kansas Medicaid program.

Based upon a State-by-State report prepared by BDO Seidman, LLP, accountants and consultants for the American Health Care Association in June 2006 ("*A REPORT ON SHORTFALLS IN MEDICAID FUNDING FOR NURSING HOME CARE*"), Kansas' Medicaid payment rates for nursing facility services fell short of covering the costs of providing care in 2003 by an average of $13.14 per patient day of care. The average Kansas payment rate in 2004 fell short of the cost of providing care by $14.16 per patient day. And according to this June 2006 report, Kansas Medicaid rates were projected to again fall short of the cost of care by $12.77 per patient day in 2006.
I do not see the situation getting any better for 2007. Nursing facilities' costs of care, i.e. qualified well trained care givers' salaries and benefits, the costs for improvements in healthcare technology and the increasingly higher acuity care needs of our patients, indicate a need for commensurate Medicaid payment rates. Senate Bill 352 can help ease the financial burden on the State while addressing the Medicaid payment rate shortfall described above.

I am submitting this testimony in support of the Kansas Nursing Facility Quality Assurance Assessment Bill, (SB 352)
I highly recommend that you support Senate Bill 352. I further hope that you will get behind this very beneficial program to see that it is ultimately adopted by the Kansas

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Legislature. I truly believe that an opportunity exists here and now to provide a substantial infusion of new monies into the Kansas Medicaid program for nursing facility services. A provider assessment program can provide that infusion of monies without drawing upon Kansas' tax payers' General Funds.

I am very familiar with the benefits that provider assessment programs, similar to the one being proposed in SB 352, have provided in several of the other states in which we provide skilled nursing facility services.

For example, in the State of Nevada, we (the provider community in partnership with the State Medicaid agency) were able to design a tremendously improved Medicaid payment system for nursing facility services. In 2003, we were able to design and implement an acuity-based payment system (a "case-mix" system), a vast improvement from the previous "flat rate system", but it would never have been possible without the additional funding generated by the provider assessment program that we (providers and the State) were able to design and convince the Center for Medicare and Medicaid Services' (CMS') to approve. The Provider Assessment program provided the level of funding necessary to support the implementation of a rational payment program that encouraged the provision of quality nursing facility care.

We had a similar, very positive, experience in the state of North Carolina in 2003, where, again, the providers and the State wanted to implement a new acuity-based Medicaid payment system but the State budget could not support the additional costs that such a payment system would entail. With the passage of authorizing legislation by the State legislature and with CMS' approval of the Provider Assessment plan, North Carolina was able to implement the needed payment system upgrades.

In Pennsylvania, in state fiscal year 2003-2004, the State budget situation was dire. Nursing facility provider's Medicaid payment rates were in danger of being cut in order for the State to find the funding necessary to balance the budget. Again, as a result of a joint State and Provider effort to design a federally acceptable Provider Assessment program, providers' payment rates were spared the budget-savings knife in a year of extreme budget deficit pressures, thus retaining the level of funding necessary to support quality care.

There are several other states that I could describe where we have had very positive experiences with a Provider Assessment program. Because of the enhanced funding produced by a Provider Assessment program, we were able to either improve the level of funding to support our staff and the quality care that they provide, or where we were able to avoid devastating budget/rate cuts; New Hampshire, Michigan, Georgia, Missouri, and Ohio are a few.

In conclusion, I ask for your support of Senate Bill 352. We believe that the Nursing Facility Quality Assurance Assessment program, described in this bill, is federally approvable, is a win-win-win program for the State, the vast majority of nursing facility service providers, and for the residents we serve. It will be a "win" for the State because it will not require the use of any State General Funds. It will be a win for nursing facility service providers because it will improve Medicaid funding for their services. And last

but not least, it will be a win for the residents of Kansas' nursing facilities by generating the needed funding for the support of quality nursing facility services in Kansas.

Thank you for considering my remarks.

With Sincere Regards,

Randall J. Sipe, Director of Medicaid Research
Fundamental Administrative Services, LLC
930 Ridgebrook Road
Sparks, MD 21152

Phone:717-266-6397

MEDICALODGES, INC.

Memorandum: Chairman Umbarger, Senate Ways and Means Committee

From: Garen Cox, President and CEO, Medicalodges, Inc.

Date: March 19, 2007

Re: Senate Bill 352

Medicalodges, Inc. operates 23 long-term care facilities in the State of Kansas. Medicalodges is the only 100 percent employee owned nursing home chain in America and the 35th largest multi-facility provider. Medicalodges employs approximately 2500 individuals.

I understand that your committee will be considering a recommendation to endorse a provider tax that would be implemented for long-term care facilities throughout the State of Kansas. This provider tax would be similar in nature to the one approved and passed several years which applies and benefits the hospitals in the state.

I wish to "weigh in" on this extremely important issue for our profession. With the increasing demands placed upon our profession, and with the budgetary concerns we face, it is now more important than ever that we, in the State, look to methods to promote and enhance the revenue available to us in order that we can afford the type of care this "greatest generation" requires and needs.

After speaking with my hospital friends, I understand what their endorsement of similar legislation meant to them. Leaving federal dollars "on the table" is not good stewardship of the resources available.

We urge your favorable handling of this matter and fully endorse any measure that would enhance our services to our residents.

Thank you for your consideration.

Garen Cox
President and CEO

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KHCA
KANSAS HEALTH CARE ASSOCIATION

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kcal ahca

Senate Ways and Means Committee
Cindy Luxem, President
Kansas Health Care Association
March 19, 2007

Chairman Umbarger and Members of the Committee:

For the past several years the Kansas Health Care Association has supported the Medicaid Provider Assessment as is described in Senate Bill 352.

This quality assessment is a legitimate funding source for federal matching funds when used to reimburse Medicaid covered services, codified in The Tax Relief and Health Care Act of 2006 by Congress. This action moved the rate from regulation to statute.

The recently enacted hospital partnership is a successful example of what you are being asked to consider today.

With the quality assessment, 97% of Kansas facilities would benefit from rate enhancements. Even facilities who are exempt from the quality assessment who have Medicaid patients, would receive a rate enhancement. In the end the quality assessment fee helps all Medicaid patients.

A total of 33 states have implemented this type of program. And eleven of those states have done so with waivers as we are suggesting. After seeing the success of the hospital provider program, it is irresponsible to oppose this option.

Medicaid funding continues to be on of the top challenges facing state legislatures. Many argue the current system is unsustainable but the federal government continues to struggle to establish a long term care strategy, while the frail and the elderly still rely almost entirely on Medicare and Medicaid to pay for their care, with relatively few individuals purchasing private insurance or making financial plans for their care as they age.

As long term care providers we have a responsibility to deliver quality care, to deliver more cost-efficient services, to be a part of the solution. But it hasn't been easy. We currently have a $14 to $16 dollar a day difference in what is reimbursed and what it costs to care for Kansas elders. That is about a $45 M gap annually and is getting wider.

Providers are seeing their Medicare dollars being cut, so the Medicaid gap will grow. Facilities will close, providers will go bankrupt and services will be lost.

We have a shared responsibility to provide quality care and this is an opportunity to work as partners with the state- One has to question how anyone would be opposed to this legislation.

Thank you. I would be happy to answer questions at anytime.

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To: The Honorable Dwayne Umbarger and
Members of the Senate Ways and Means Committee
From: Tom Church, CEO, Catholic Care Center
Date: Monday, March 19, 2007

Testimony in Opposition to Senate Bill 352

Good Morning, Mr. Chairman and Members of the Committee. Thank you for this opportunity to come before you today to share my deep concerns about Senate Bill 352.

My name is Tom Church and I am the CEO of the Catholic Care Center, the largest nursing facility in Sedgwick County. Sponsored by the Catholic Diocese of Wichita and the Via Christi Health System, we are licensed for 178 beds of skilled nursing and 120 beds of assisted living, with 40 of these beds being a specialty Alzheimer center. As I read it, we would be exempt from the provider tax as proposed in SB 352 as we are a part of a continuing care retirement community. Even so, I speak in opposition of this bill.

As a not-for-profit faith-based community we oppose SB 352 for the following reasons:

- As an advocate for a most frail and vulnerable population that is already shouldering the variance between the nursing facility Medicaid reimbursement rate and private pay rate, a provider tax assessment is adding insult to injury.
- This bill would accelerate the depletion of private pay resident's assets. At $2 per bed per day, a facility like the Catholic Care Center could pay over $120,000 in taxes annually. Over $50,000 of that amount would have to come from our private pay residents.
- As a long term care administrator I am obligated to be on the lookout for abuse, neglect and exploitation of the frail elders who reside at Catholic Care Center. In my mind, SB 352 raises the question of exploitation, because there is no guarantee of benefit to these residents. Who will be the voice questioning whether this might not be taxation without representation for those elders who cannot challenge this themselves?
- As a mission driven organization I have asked myself, "Who are the potential beneficiaries of this proposal?" The fact that the "not-for-profits" are pretty much aligned against the bill, and the "for-profits" pretty much aligned for it raises questions. The creation of a system that creates winners and losers is not fair and bears significant further review.
- While the bill purports "to increase the quality and quantity of nursing care," there is nothing specific in the bill that speaks to assurance of quality or increase of quantity. Therefore the prudent person could quickly deduce that the bill on its face is about nothing other than the money that would flow strongly to some at the expense of others.
- We must also ask what the likely and unintended consequences would be if this bill passed. This subject does not appear to have been addressed and bears significant study. If funding is not guaranteed to facilities from the provider tax, what services will have to be curtailed, what quality of life diminished?

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We are committed to doing the right thing for the right reasons and this bill just does not ring true on either count. We are committed to providing the services people need when they need them, in a place they call home. This bill does not move us in that direction. I respectfully ask this Committee to take no action or, better yet, defeat SB 352. Thank you for your consideration to that end.

Eastridge Skilled Nursing Facility

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To: Senator Dwayne Umbarger, Chair and Members
Senate Ways and Means Committee
From: Pam Bachman, Administrator
Date: March 19, 2007

Please Oppose House SB 352

Thank you Chairman Umbarger, and Members of the Committee for the opportunity to provide written testimony regarding SB **352**.

I have been the Administrator of Eastridge Skilled Nursing Facility, a small 41-bed facility in Centralia, for the past 13 years. Eastridge was opened by the community in 1990, and in 1996 we became a division of Community Hospital Onaga, Inc. At Eastridge we take care of the frailest, oldest and most vulnerable people in our community.

I ask you to oppose House SB **352**.

In my 13 years at Eastridge, I have seen many elders spend down their resources and eventually become dependent on Medicaid. It is a very humiliating experience for most of these residents to have to turn to Medicaid to pay for their care needs. I understand this personally. My 97 year old grandmother had to turn to Medicaid in the last year of her life, after she paid for five years of nursing home care out of her own pocket.

House SB 352 will speed up the process of depletion of private funds to pay for nursing home care. When I add it up, according to House SB 352, my facility would have to pay over $25,000 in the first year for this tax, nearly $14,000 of which will have to be passed directly on to residents who are paying for their own care. I know of several small rural nursing homes that will find it hard to survive if they do not get the amount they pay in tax returned, since they barely break even now. Any additional expense can be devastating to small free-standing facilities. Any extra tax burden will push small homes out of business and residents will have no where to go.

I do not want to have to go to my residents and tell them that they are going to have to pay a tax on their care. I don't want to tell Mrs. D, a 93 year old widow and retired school teacher who has lived with us for some time now. Until two years ago, she was still living in her family home where she and her husband raised their 4 children. Several years ago her daughter moved back from Colorado to care for her so she could stay at home. Only when the daughter's health failed did Mrs. D. turn to us for care.

I've heard some people say that the state should implement a nursing home tax like they did on the hospitals. I'd like to speak briefly to this because I also serve as the Facility Director for Community Hospital Onaga. There is one basic difference between a hospital tax and a nursing home tax. Very few hospital patients pay their bills directly. But at Eastridge over half of our residents pay their bills directly from their own pockets.

While, I am hopeful that the hospital assessment will be a good thing, it is still premature to make a judgment.

I appreciate your attention to all aspects and potential consequences of this bill and thank you for the ability to provide this written testimony to you today.

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AN ACT concerning the Kansas state schools for the blind and the deaf; relating to the rates of compensation for teachers employed thereby.

Be it enacted by the Legislature of the State of Kansas:

Section 1. On and after July 1, 2007, each person employed by the Kansas state school for the blind as a teacher, as defined by K.S.A. 76-11a04 and amendments thereto, during a school year shall be paid compensation for such employment at a rate that is not less than the rate of compensation that is paid to a teacher employed by unified school district no. 233, Olathe, Kansas, as of September 1 of such school year, who has comparable or substantially the same levels of education and experience as the person employed by the Kansas state school for the blind or, if no such teacher is employed by such school district for such school year, then such person employed by the Kansas state school for the blind shall be paid compensation at a rate that is not less than the rate of compensation that would be paid to such a teacher employed by unified school district no. 233, Olathe, Kansas, as of September 1 of such school year.

Sec. 2. On and after July 1, 2007, each person employed by the Kansas state school for the deaf as a teacher, as defined by K.S.A. 76-11a04 and amendments thereto, ***or as another professional service provider requiring professional licensure or certification,*** during a school year, shall be paid compensation for such employment at a rate that is not less than the rate of compensation that is paid to a teacher employed by unified school district no. 233, Olathe, Kansas, as of September 1 of such school year, who has comparable or substantially the same levels of education and experience as the person employed by the Kansas state school for the deaf or, if no such teacher is employed by such school district for such school year, then such person employed by the Kansas state school for the deaf shall be paid compensation at a rate that is not less than the rate of compensation that would be paid to such a teacher employed by unified school district no. 233, Olathe, Kansas, as of September 1 of such school year.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

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