Local Health Departments
Public Notice
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State of Kansas
Department for Aging and Disability Services
Kansas Department of Health and Environment,
Division of Health Care Finance

Notice of Final Nursing Facility Medicaid Rates for State Fiscal Year 2026; Methodology for Calculating Rates, and Rate Justifications; Response to Written Comments; Notice of Intent to Amend the Medicaid State Plan

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

As required by 42 U.S.C. 1396a(a)(13), as amended by Section 4711 of the Balanced Budget Act of 1997, P.L. No. 105-33, 101 Stat. 251, 507-08 (August 5, 1997), the Secretary of the Kansas Department for Aging and Disability Services (KDADS) is publishing the revised final Medicaid per diem rates for Medicaid-certified nursing facilities for State Fiscal Year 2026, the methodology underlying the establishment of the nursing facility rates, and the justifications for those rates. KDADS and DHCF are also providing notice of the state's intent to submit amendments to the Medicaid State Plan to the U. S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) on or before September 30, 2025.

The Federal fiscal impact for Fee for Service is as follows:

Fee-For-Service Only	Estimated Federal Financial Participation
FFY 2025 (July-Sept 2025	($729,292)
FFY 2026 (Oct-June)	$630,716

Response to Comments Received

The state did not receive formal comments to its Proposed Nursing Facility rates published on April 10, 2025 in the Kansas Register. The review of this final notice ends on July 12, 2025.

Notice of Intent to Amend the Medicaid State Plan

The state intends to submit Medicaid State Plan amendments to CMS on or before September 30, 2025.

Laura Howard
Secretary
Kansas Department for Aging and Disability Services

Christine Osterlund
Medicaid Director
Deputy Secretary for Agency Integration and Medicaid
Kansas Department of Health and Environment
Division of Health Care Finance

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Department for Aging and Disability Services
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I. Methodology Used to Calculate Medicaid Per Diem Rates for Nursing Facilities.

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

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

1. Attachment 4.19D, Part I, Subpart C, Exhibit C-1, inclusive;
2. Medicaid Add-On

The text of the portions of the Medicaid State Plan identified above in section IA.1, but not the documents, authorities and the materials incorporated therein by reference, is reprinted in this notice. The Medicaid State Plan provisions set out in this notice appears in the version which the state currently intends to submit to CMS on or before September 30, 2025. The Medicaid State Plan amendment that the state ultimately submits to CMS may differ from the version contained in this notice.

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

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

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

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

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 129-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care, and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease, and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

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

Calendar Year End Cost Reports:

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

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

Projected Cost Reports:

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

2) Rate Determination

Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2022, 2023, and 2024.

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

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

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per diem cost, each year's cost data is adjusted from the midpoint of that year to December 31, 2025. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

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

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

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

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

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

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to December 31, 2025. This adjustment will be based on the S&P Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index (S&P Index). The S&P indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2025. The provider shall remain in new enrollment status until the base data period is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

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

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2022-2024. If

base cost data is not available, the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider.

All data used to set rates for facilities recognized as a change-of-provider shall be adjusted to December 31, 2025. This adjustment will be based on the S&P Index. The S&P indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2025. The provider shall remain in change-of-provider status until the base data period is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

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

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

All cost data used to set rates for facilities reentering the program shall be adjusted to December 31, 2025. This adjustment will be based on the S&P Global Index. The S&P Global indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2025. The provider shall remain in reenrollment status until the base data period is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in reenrollment status.

3) Quarterly Case Mix Index Calculation

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

Effective July 1, 2025, the Patient Driven Payment Model (PDPM) Nursing component classification is used as the resident classification system to determine all case- mix indices, using data from the MDS submitted by each facility. The 25 PDPM case mix groups (CMG) and corresponding case mix indices (CMI) (developed by the Centers for Medicare and Medicaid Services (CMS) and implemented as of October 1, 2019) are used to determine facility average CMIs and to adjust the Direct Health Care

costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a PDPM nursing CMG calculated on the resident's most current assessment available on the first day of each calendar quarter. This PDPM nursing CMG shall be translated to the corresponding CMI based on the PDPM weights effective October 1, 2019. From the individual resident case mix indices, average case mix indices for all residents and for each payment source type (Medicaid, Medicare and Other) are calculated for each Medicaid nursing facility four times per year based on the assessment information available on the first day of each calendar quarter.

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

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

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

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

4) Resident Days

Facilities with 60 beds or less:

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

Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

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

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

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to December 31, 2025. The inflation will be based on the S&P Global, CMS Nursing Home without Capital Market Basket index.

The S&P Global, CMS Nursing Home without Capital Market Basket Indices listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may

require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

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

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

6) Upper Payment Limits

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

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

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

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

Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2024 historic cost reports in the database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

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

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit is 105% of the median determined from a total resident day-weighted array of the property fees in effect April 1, 2025.

Cost Center Upper Payment Limits

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

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

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to December 31, 2025. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the S&P Global, CMS Nursing Home Without Capital Market Basket Index.

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

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

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

Direct Health Care Cost Center Limit:

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

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

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

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

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

for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are eight million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $150 and the upper payment limit is based on 130% of the median, then the upper payment limit for the statewide average CMI would be $195 (**D**=130% x $150).

7) Quarterly Case Mix Rate Adjustment

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

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

The Medicaid Acuity Adjustment is calculated semi-annually to account for changes in the Medicaid CMI. To illustrate this calculation, take the following situation: The facility's direct health care per diem cost is $120.00, the Direct Health Care per diem limit is $195.00, and these are both tied to a statewide average CMI of 1.000, and the facility's current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $120.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the result by the Allowable Direct Health Care Cost. In this case that would result in $108.00 (0.9000/1.0000 x $120.00). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next semi-annual adjustment rose to 1.1000, the Medicaid Acuity Adjustment would be $132.00 (1.1000/1.0000 x $120.00). Again, the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

8) Real and Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable

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

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

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

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

9) Incentive Factors

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

Nursing Facility Quality and Efficiency Incentive Factor:

The Nursing Facility Incentive Factor is a per diem amount determined by four per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $3.00 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.50 per diem add-on. Providers that achieve a staff retention rate at or above the 75th percentile will earn a $2.50 per diem add-on as long as contracted labor costs do not exceed 10% of the provider's total direct

health care labor costs. Providers that have a staff retention rate lower than the 75th percentile but that increase their staff retention rate by 10% or more will receive a per diem add-on of $0.50 as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a Medicaid occupancy percentage of 65% or more will receive a $0.75 per diem add-on. Finally, providers that maintain quality measures at or above the 75th percentile will earn a $1.25 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

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

INCENTIVE OUTCOME	INCENTIVE ADD-ONS
CMI adjusted staffing ratio >= 75th percentile (5.80), or CMI adjusted staffing < 75th percentile but improved >= 10%	$3.00 $0.50
Staff retention rate >= 75th percentile, 69% Contracted labor < 10% of total direct health care labor costs or Staff retention rate < 75th percentile but increased >= 10% Contracted labor < 10% of total direct health care labor costs	$2.50 $0.50
Medicaid occupancy >= 65%	$0.75
Quality Measures >=75th percentile (600)	$1.25
Total Incentive Add-on Available	**$7.50**

The Culture Change/Person-Centered Care Incentive Program

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

Each incentive level has a specific pay-for-performance incentive per diem attached to it that homes can earn by meeting defined outcomes. The first six levels (Level 0 – Level 5) are intended to encourage quality improvement for homes that have not yet met the minimum competency requirements for a person-centered care home.

Level 6 recognizes those homes that have attained a minimum level of core competency in person-centered care. Level 7 and Level 8 are reserved for those homes that have demonstrated sustained person-centered care for multiple years and have gone on to mentor other homes in their pursuit of person-centered care. The table below provides a brief overview of each of the levels.

LEVEL & PER DIEM INCENTIVE	SUMMARY OF REQUIRED NURSING HOME ACTION	INCENTIVE DURATION
LEVEL 0: The Foundation $0.50 Per Medicaid Resident Per Day (PMRPD)	Home completes a self-evaluation tool according to the enrollment instructions. Home participates in all required activities noted in the Foundation timeline and Workbook. Homes that do not complete the requirements at this level must sit out for the remainder of the program year. At successful completion of the Foundation level, homes move to Level 1.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year, provided the home participates in program activities. Homes' incentive may be dropped mid-year for non-participation. Receipt of incentive also based on survey eligibility.
LEVEL 1: 0-2 Cores $0.75 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 1 incentive by passing the Foundation level and/or sustaining practices in 1-2 cores. Level 1 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 2: 3-4 Cores $1.00 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 2 incentive by passing and/or sustaining 3-4 cores. Level 2 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 3: 5-6 Cores $1.25 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 3 incentive by passing and/or sustaining 5-6 cores. Level 3 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 4: 7-8 Cores $1.50 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 4 incentive by passing and/or sustaining 7-8 cores. Level 4 homes undergo an in-person or Zoom evaluation	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.

	with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	
LEVEL 5: 9-11 Cores $1.75 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 5 incentive by passing and/or sustaining 9-11 cores. Level 5 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 6: 12 Cores Person-Centered Care Home $2.00 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 6 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices). The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices. KDADS will make final determination of movement to level 6.	Available beginning July 1 following confirmed minimum competency of person-centered practice. Incentive is granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 7: 12 Cores Sustained Person-Centered Care Home $2.50 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 7 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices) two consecutive years. The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices. KDADS will make final determination of movement to level 7.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies in all 12 PEAK cores for the second consecutive year. Incentive is granted for two fiscal years. Renewable biannually. Receipt of incentive also based on survey eligibility.
LEVEL 8: 12 Cores Mentor Home $3.00 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 8 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices) two consecutive years and meeting the minimum mentoring activities, as directed in the mentoring log. The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices bi-annually and turning in a mentor log. KDADS will make final determination of movement to level 8.	Available beginning July 1 following confirmation of mentor home standards (upkeep of minimum person-centered care competencies in all 12 PEAK cores and mentoring points). Incentive is granted for two fiscal years. Renewable bi-annually. Receipt of incentive also based on survey eligibility.

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from nursing facilities. Nursing Facilities for Mental Health serve people who often do not need the NF level of care on a long-term

basis. There is a desire to provide incentive for NFMHs to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

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

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 3.50, which is 120% of the statewide NFMH median of 2.92. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.21, which is 110% of the statewide NFMH median. Providers with staffing ratios below 110% of the NFMH median will receive no points for this incentive measure.

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

NFMH providers may earn one point for low operating expense outcomes measures. The provider will earn one point if the per diem operating expenses are below $33.71, or 90% of the statewide median of $37.45.

NFMH providers may earn up to two points for the turnover rate outcomes measure. Providers with direct health care staff turnover equal to or below 52%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover greater than 52% but equal to or below 75%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for the retention rate outcomes measure. Providers with staff retention rates at or above 76%, the 75th percentile statewide will earn two points. Providers with staff retention rates below 76% but at or above 67%, the 50th percentile statewide, will earn one point.

The table below summarizes the incentive factor outcomes and points:

QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 120% (3.50) of NF-MH median (2.92), or	2, or

CMI adjusted staffing ratio between 110% (3.21) and 120%	1
Total occupancy <= 90%	1
Operating expenses < $33.71, 90% of NF-MH median, $37.45	1
Staff turnover rate <= 75th percentile, 52% Staff turnover rate <= 50th percentile, 75% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 76% Staff retention >= 50th percentile, 67%	2, or 1
Total Incentive Points Available	**8**

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

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

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

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

10) Rate Effective Date

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

11) Retroactive Rate Adjustments

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

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

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

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

A.2 Medicaid Add-On

To compensate and incentivize providers with high Medicaid participation a per diem add-on has been determined and will be paid to each Medicaid provider in SFY26. The per diem will be added to the nursing facility Medicaid per diem rate.

1) **Qualifying Providers**
   All providers currently enrolled in the Medicaid program will be eligible for the add-on.
2) **Medicaid Add-On Calculation:**
   Funds allocated for the add-on are in a flat rate of $20.00 per Medicaid resident day. Each facility's Medicaid rate will be determined by adding $20.00 to the facility's base SFY26 per diem rate. This $20.00 Medicaid add-on is reflected in the calculation of all providers' Daily Rates, which are listed under II.C ("Rates").

A.3 Rapid Response Staffing Grant Adjustment

The Kansas Department of Health and Environment began partnering with KFMC Health Improvement Partners (KFMC) in 2022 to assist long-term care facilities impacted by COVID-19 with emergency temporary staffing services through the Rapid Response Staffing Support Center Grant program. This program provides qualifying nursing facilities with short-term (up to two weeks) emergency staffing services. The costs of the emergency staffing services provided to each facility are covered entirely by the program with no expenditures from the facility. Therefore, this additional staffing and the costs related to it are not reflected in the Medicaid cost reports. To account for grant program expenditures made on behalf of each Medicaid nursing facility, a Rapid Response Staffing Grant Adjustment will be added to each participating facility's total reported Direct Health Care Costs for each applicable year in the base cost data period. The Rapid Response Staffing Grant Adjustment will reflect the amount of grant funds

expended in a given cost report year to provide emergency staffing services to the facility. This amount will be combined with the total reported costs and cost report adjustments to determine the total adjusted costs for Direct Health Care for each cost report year included in the base data period. The grant expenditures will be subject to inflation and case mix adjustments applied to the Direct Health Care costs for each year. The grant expenditures will then flow through the rate calculation as part of the Direct Health Care costs subject to the cost center limitation and Medicaid acuity adjustment to determine the Direct Health Care per diem rate component.

1) **Qualifying Providers**
   All providers identified by KFMC as receiving emergency temporary staffing services through the Rapid Response Staffing Support Center Grant program.

2) **Rapid Response Staffing Grant Adjustment:**
   The annual grant expenditure amount made on behalf of each facility will be added to the Direct Health Care costs prior to adjusting for inflation and case mix.

II. Medicaid Per Diem Rates for Kansas Nursing Facilities

A Cost Center Limitations: The state establishes the following cost center limitations which are used in setting rates effective July 1, 2025.

Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	$60.48
Indirect Health Care	115% of the Median Cost	$73.49
Direct Health Care	130% of the Median Cost	$200.30
Real and Personal Property Fee	105% of the Median Fee	$10.69

These amounts were determined according to the “Reimbursement Limitations” section. The Direct Healthcare Limit is calculated based on a CMI of 1.2921, which is the statewide average for the three-year base cost data period.

B. Case Mix Index: These revised final rates are based upon each nursing facility’s Medicaid CMI calculated as the average of the quarterly Medicaid CMI averages with the cutoff dates of January 1, 2025 and April 1, 2025. The CMI calculations use PDPM Nursing component CMI values implemented by CMS effective October 1, 2019. In Section II.C below, each nursing facility’s Medicaid average CMI is listed beside its per diem rate.

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

Facility Name	City	Daily Rate	Medicaid CMI
Village Manor	Abilene	345.88	1.0945

Life Care Center of Andover	Andover	244.47	1.3983
Anthony Community Care Center	Anthony	277.55	1.1825
Arkansas City Presbyterian Manor	Arkansas City	293.53	1.1067
Medicalodges Health Care Ctr Arkansas	Arkansas City	269.25	1.2240
Arma Operator, LLC	Arma	299.89	1.7619
Atchison Senior Village Rehab & NC	Atchison	382.83	1.5641
Dooley Center	Atchison	324.49	0.9441
Medicalodges Atchison	Atchison	306.89	1.3203
Attica Long Term Care	Attica	364.11	1.1541
Good Samaritan Society-Atwood	Atwood	342.39	1.2925
Lake Point Nursing Center	Augusta	260.87	1.2842
Baldwin Healthcare & Rehab Center	Baldwin City	322.98	1.4881
Quaker Hill Manor	Baxter Springs	268.25	1.1322
Catholic Care Center Inc.	Bel Aire	347.62	1.2850
Belleville Healthcare and Rehab Ctr	Belleville	334.35	1.6291
Hilltop Lodge Health and Rehab	Beloit	340.31	1.9452
Mitchell County Hospital LTCU	Beloit	350.15	1.1967
Advena Living of Bonner Springs	Bonner Springs	312.29	1.3239
Hill Top House	Bucklin	324.74	1.2251
Buhler Sunshine Home, Inc.	Buhler	330.41	1.2198
Life Care Center of Burlington	Burlington	301.31	1.2780
Eastridge Nursing Home	Centralia	383.18	1.3701
Diversicare of Chanute	Chanute	278.72	1.3456
Heritage Health Care Center	Chanute	254.58	1.2877
Chapman Valley Manor	Chapman	291.63	1.2047
Cheney Golden Age Home Inc.	Cheney	307.13	1.2026
Advena Living of Cherryvale	Cherryvale	249.69	1.1717
The Shepherd's Center	Cimarron	302.64	1.1053
Advena Living of Clay Center	Clay Center	270.07	1.0771
Clay Center Presbyterian Manor	Clay Center	309.16	1.0792
Advena Living of Clearwater	Clearwater	285.96	1.1880
Park Villa Nursing Home	Clyde	262.06	1.0658
Medicalodges Coffeyville on Midland	Coffeyville	304.75	1.2694
Colby Operator, LLC	Colby	408.56	1.9166
Prairie Senior Living Complex	Colby	362.77	1.2621
Pioneer Lodge	Coldwater	289.41	1.1470
Medicalodges Columbus	Columbus	312.30	1.2914
Sunset Home, Inc.	Concordia	297.35	1.3013
Spring View Manor Healthcare & Rehab	Conway Springs	288.17	1.4703
Chase County Care and Rehab	Cottonwood Falls	386.44	1.7849
Diversicare of Council Grove	Council Grove	262.45	1.2953
Hilltop Manor Nursing Center	Cunningham	290.11	1.4733

Derby Health and Rehabilitation	Derby	358.22	1.5264
Westview of Derby Rehab & Health	Derby	257.73	1.2935
Hillside Village of DeSoto	DeSoto	280.84	1.4112
Manor of the Plains	Dodge City	351.42	1.3045
Sunporch of Dodge City	Dodge City	314.67	1.0723
Trinity Manor	Dodge City	295.52	1.1909
Downs Care and Rehab	Downs	335.19	1.6266
Anew Healthcare Easton	Easton	297.30	1.4547
Edwardsville Care and Rehab	Edwardsville	206.42	1.0733
Kaw River Care and Rehab	Edwardsville	325.52	1.6283
Parkway Care and Rehab	Edwardsville	292.49	1.5479
El Dorado Care and Rehab	El Dorado	348.13	1.6103
Lakepoint Nursing Center-El Dorado	El Dorado	277.00	1.2747
Good Samaritan Society-Ellis	Ellis	283.07	1.2110
Good Sam Society-Ellsworth Village	Ellsworth	330.20	1.3926
Emporia Presbyterian Manor	Emporia	315.43	1.2242
Flint Hills Care and Rehab Center	Emporia	274.55	1.4506
Enterprise Estates Nursing Center, I	Enterprise	295.74	1.2830
Eskridge Care and Rehab	Eskridge	261.65	1.1830
Medicalodges Eudora	Eudora	299.05	1.2366
Eureka Nursing Center	Eureka	251.46	1.2847
Kansas Soldiers' Home	Fort Dodge	356.66	1.3075
Medicalodges Fort Scott	Fort Scott	257.35	1.0973
Fowler Residential Care	Fowler	322.60	1.0486
Frankfort Community Care Home, Inc.	Frankfort	308.77	1.0198
Medicalodges Frontenac	Frontenac	267.29	1.2989
Galena Nursing Home	Galena	246.52	1.1119
Garden Valley Retirement Village	Garden City	240.61	1.2679
Ranch House Senior Living	Garden City	290.49	1.4012
Recover Care Meadowbrook Rehab, LLC	Gardner	435.78	1.7345
Anderson County Hospital	Garnett	338.09	1.0554
Parkview Heights Nursing and Rehab	Garnett	300.44	1.3612
The Nicol Home, Inc.	Glasco	265.06	1.1420
Medicalodges Goddard	Goddard	293.72	1.2254
Bethesda Home	Goessel	373.26	1.3464
Topside Manor, Inc	Goodland	306.62	1.1125
Azria Health Great Bend	Great Bend	302.53	1.6913
Medicalodges Great Bend	Great Bend	337.60	1.1963
Halstead Health and Rehab Center	Halstead	252.47	1.1878
Haviland Operator, LLC	Haviland	197.75	0.9671
Ascension Living Via Christi Village	Hays	336.07	1.1654
Good Samaritan Society-Hays	Hays	304.02	1.4207
Diversicare of Haysville	Haysville	238.08	1.4260

Legacy at Herington	Herington	308.44	1.3202
Schowalter Villa	Hesston	354.66	1.1362
Maple Heights Nursing & Rehabilitative Center	Hiawatha	256.47	1.2640
Dawson Place, Inc.	Hill City	284.96	1.2532
Parkside Homes, Inc.	Hillsboro	306.55	1.2630
Salem Home	Hillsboro	292.39	1.2620
Anew Healthcare Holton	Holton	363.44	1.3682
Sheridan County Hospital	Hoxie	363.09	1.2885
Pioneer Manor	Hugoton	338.47	1.1542
Diversicare of Hutchinson	Hutchinson	299.70	1.2832
Good Sam Society-Hutchinson Village	Hutchinson	303.40	1.1393
Hutchinson Operator, LLC	Hutchinson	321.14	1.4863
Wesley Towers	Hutchinson	289.85	1.0397
Medicalodges Independence	Independence	259.31	1.1830
Montgomery Place Nursing Center, LLC	Independence	248.45	1.2055
Pleasant View Home	Inman	327.51	1.2146
Medicalodges Iola	Iola	314.25	1.1558
Stanton County Hospital- LTCU	Johnson	349.89	1.2036
Valley View Senior Life	Junction City	281.27	1.2618
Ignite Med Resort Rainbow Blvd, LLC	Kansas City	323.95	1.5239
Lifecare Center of Kansas City	Kansas City	277.28	1.0984
Medicalodges Post Acute Care Center	Kansas City	290.79	1.1733
Providence Place LTCU	Kansas City	377.86	1.4849
Riverbend Post Acute Rehabilitation	Kansas City	323.47	1.4907
The Healthcare Resort of Kansas City	Kansas City	345.33	1.3337
The Wheatlands	Kingman	289.81	1.4912
Medicalodges Kinsley	Kinsley	316.01	1.1725
Kiowa District Manor	Kiowa	317.68	1.0553
Locust Grove Village	Lacrosse	271.09	1.0760
High Plains Retirement Village	Lakin	395.22	1.5591
Lansing Care and Rehab	Lansing	312.98	1.4208
Twin Oaks Health & Rehab	Lansing	295.43	1.3104
Diversicare of Larned	Larned	249.90	1.1507
Lawrence Presbyterian Manor	Lawrence	352.70	1.1778
Pioneer Ridge Retirement Community	Lawrence	247.27	1.2178
Medicalodges Leavenworth	Leavenworth	355.81	1.5122
The Healthcare Resort of Leawood	Leawood	370.80	1.5560
Delmar Gardens of Lenexa	Lenexa	258.94	1.2226
Lakeview Village	Lenexa	340.20	1.0811
Westchester Village of Lenexa	Lenexa	439.82	1.8500
Leonardville Nursing Home	Leonardville	328.54	1.1723
Wichita County Health Center	Leoti	294.67	0.8438
Good Samaritan Society-Liberal	Liberal	312.64	1.3114

Wheatridge Park Care Center	Liberal	295.86	1.2852
Lincoln Park Manor, Inc.	Lincoln	294.83	1.1974
Bethany Home Association	Lindsborg	332.63	1.0631
Linn Community Nursing Home	Linn	281.71	1.4164
Sandstone Heights Nursing Home	Little River	340.01	1.2319
Logan Manor Community Health Service	Logan	299.40	1.2550
Louisburg Healthcare and Rehab Center	Louisburg	357.34	1.6971
Ascension Living Via Christi Village	Manhattan	312.11	1.1979
Meadowlark Hills Retirement Community	Manhattan	353.32	1.2595
Stoneybrook Retirement Community	Manhattan	283.30	1.3744
St. Luke Living Center	Marion	306.14	1.2259
Riverview Estates, Inc.	Marquette	327.94	1.3292
Cambridge Place	Marysville	283.64	1.5314
McPherson Operator, LLC	McPherson	342.19	2.0320
The Cedars, Inc.	McPherson	351.42	1.1773
Lone Tree Retirement Community LLC	Meade	336.64	1.0872
Merriam Gardens Healthcare & Rehab	Merriam	307.40	1.4376
Minneapolis Healthcare and Rehab	Minneapolis	305.10	1.6574
Minneola District Hospital-LTCU	Minneola	355.11	1.2387
Bethel Home, Inc.	Montezuma	299.59	1.0946
Moran Manor	Moran	245.22	1.1932
Moundridge Manor, Inc.	Moundridge	322.82	1.1287
Pine Village	Moundridge	317.15	1.2869
Villa Maria, Inc.	Mulvane	304.80	1.1870
Neodesha Care and Rehab	Neodesha	298.93	1.5811
Ness County Hospital Dist.#2	Ness City	336.63	1.0662
Kansas Christian Home	Newton	326.34	1.2641
Newton Presbyterian Manor	Newton	330.09	1.1163
Paramount Community Living and Rehab	Newton	328.36	1.3617
Bethel Care Center	North Newton	385.64	1.3779
Andbe Home, Inc.	Norton	255.88	1.0864
Anew Healthcare	Nortonville	280.18	1.4495
Logan County Senior Living	Oakley	350.99	1.2418
Good Samaritan Society-Decatur Co.	Oberlin	325.36	1.0888
Aberdeen Village, Inc.	Olathe	371.27	1.3284
Azria Health at Olathe	Olathe	341.65	1.4636
Evergreen Community of Johnson Count	Olathe	366.00	1.3021
Good Samaritan Society-Olathe	Olathe	363.61	1.2791
Nottingham Health & Rehab	Olathe	362.80	1.1586
The Healthcare Resort of Olathe	Olathe	378.51	1.7919
Villa St. Francis Catholic Care Ctr.	Olathe	365.31	1.4659
Onaga Operator, LLC	Onaga	310.04	1.5036
Osage Nursing & Rehab Center	Osage City	269.34	1.1718

Parkview Health and Rehab LLC	Osborne	275.83	1.5193
Heritage Gardens Health and Rehab	Oskaloosa	366.25	1.5766
Oswego Operator, LLC	Oswego	294.60	1.6060
Rock Creek of Ottawa	Ottawa	319.32	1.7399
Brookside Manor	Overbrook	286.25	1.3138
Aspen Health and Wellness	Overland Park	344.32	1.5458
Brookdale Overland Park	Overland Park	378.44	1.3950
Colonial Village	Overland Park	359.91	1.3030
Delmar Gardens of Overland Park	Overland Park	339.64	1.3433
Excel Healthcare and Rehab OP	Overland Park	337.28	1.2141
Garden Terrace at Overland Park	Overland Park	300.08	1.2317
Ignite Medical Resort Overland Park	Overland Park	413.44	1.4806
Shawnee Post Acute Rehab Center	Overland Park	371.07	1.6251
Stratford Commons Rehab & HCC	Overland Park	360.31	1.5428
Swan Health at Overland Park	Overland Park	448.16	3.0189
Tallgrass Creek, Inc.	Overland Park	424.35	1.6434
Village Shalom, Inc.	Overland Park	353.64	1.1794
Medicalodges Paola	Paola	179.67	0.8761
North Point Skilled Nursing Center	Paola	262.01	1.2607
Elmhaven East	Parsons	250.29	1.1789
Good Samaritan Society-Parsons	Parsons	296.03	1.1355
Parsons Presbyterian Manor	Parsons	332.90	1.1544
Access Mental Health	Peabody	189.98	0.9195
Peabody Operator, LLC	Peabody	248.06	1.1292
Phillips County Retirement Center	Phillipsburg	275.04	1.1596
Ascension Living Via Christi Village	Pittsburg	325.74	1.3213
Medicalodges Pittsburg South	Pittsburg	315.21	1.2383
Pittsburg Care and Rehab	Pittsburg	271.56	1.4723
Rooks County Senior Services, Inc.	Plainville	329.09	1.2894
The Village at Mission	Prairie Village	394.18	1.4603
Grand Plains - Skilled Nursing	Pratt	260.63	1.2515
Pratt Operator, LLC	Pratt	313.83	1.9645
Prairie Sunset Manor	Pretty Prairie	329.38	1.5856
Protection Valley Manor	Protection	254.97	1.0394
Richmond Healthcare and Rehab Center	Richmond	313.88	1.5320
Advena Living at Fountainview	Rose Hill	259.54	1.0284
Rossville Healthcare and Rehab Center	Rossville	331.54	1.5787
Russell Regional Hospital	Russell	349.58	1.1563
Wheatland Nursing & Rehab Center	Russell	241.65	1.1996
Apostolic Christian Home	Sabetha	314.17	1.2015
Sabetha Nursing Center	Sabetha	246.05	1.0287
Holiday Resort of Salina	Salina	295.18	1.3334
Kenwood View Health and Rehab Center	Salina	303.92	1.6812

Pinnacle Park Nursing and Rehabilitation	Salina	315.88	1.5897
Salina Presbyterian Manor	Salina	329.87	1.1804
Salina Windsor SNF OPCO, LLC	Salina	254.71	1.1794
Smoky Hill Rehabilitation Center	Salina	261.28	1.5059
Park Lane Nursing Home	Scott City	351.47	1.2877
Pleasant Valley Manor	Sedan	231.09	1.1598
Diversicare of Sedgwick	Sedgwick	325.50	1.3540
Crestview Nursing & Residential Living	Seneca	262.17	1.1584
Life Care Center of Seneca	Seneca	287.81	1.2911
Brookdale Rosehill	Shawnee	376.37	1.3650
Sharon Lane Health and Rehabilitation	Shawnee	276.33	1.1929
Shawnee Gardens Healthcare and Rehab	Shawnee	322.20	1.5306
Smith Center Operator, LLC	Smith Center	283.63	1.7710
Sunporch of Smith County	Smith Center	330.36	1.2129
Mennonite Friendship Manor, Inc.	South Hutchinson	362.41	1.4280
Southwinds at Spearville	Spearville	324.85	1.2779
Spring Hill Care and Rehab	Spring Hill	320.73	1.6674
Cheyenne County Village,,Inc.	St. Francis	367.09	1.3965
Community Hospital of Onaga, LTCU	St. Mary's	374.77	1.2986
Prairie Mission Retirement Village	St. Paul	257.01	1.0909
Leisure Homestead at Stafford	Stafford	271.59	1.2598
Sterling Village	Sterling	360.48	1.2819
Solomon Valley Manor	Stockton	286.92	1.1859
Tonganoxie Opco LLC	Tonganoxie	308.94	1.3007
Advena Living on Tenth	Topeka	258.11	1.0864
Brewster Health Center	Topeka	356.47	1.2296
Brighton Place North	Topeka	139.44	0.9926
Brighton Place West Health Center	Topeka	258.65	1.3868
Countryside Health Center	Topeka	148.27	1.0074
Lexington Park Nursing and Post Acute	Topeka	337.23	1.5631
McCrite Plaza Health Center	Topeka	326.30	1.4536
Providence OpCo LLC	Topeka	219.83	1.0772
Recover-Care Plaza West Care Center	Topeka	295.17	1.6754
Rolling Hills Health Center	Topeka	241.63	1.2037
Tanglewood Nursing and Rehabilitation	Topeka	253.72	1.3574
The Gardens at Aldersgate	Topeka	340.79	1.6757
The Healthcare Resort of Topeka	Topeka	344.45	1.9950
Topeka Presbyterian Manor Inc.	Topeka	372.71	1.3207
Greeley County Hospital, LTCU	Tribune	333.47	1.2270
Western Prairie Senior Living	Ulysses	293.16	1.2761
Valley Health Care Center	Valley Falls	222.90	0.9515
Trego Co. Lemke Memorial LTCU	Wakeeney	318.30	1.0297

Wakefield Care and Rehab	Wakefield	330.31	1.5973
Good Samaritan Society-Valley Vista	Wamego	294.12	1.1587
Wathena Healthcare and Rehab Center	Wathena	336.51	1.6935
Botkin Care and Rehab	Wellington	253.82	1.2749
Sumner Operator, LLC	Wellington	265.87	1.2939
Wellsville Manor	Wellsville	273.07	1.3356
Westy Community Care Home	Westmoreland	265.79	1.0369
Wheat State Manor	Whitewater	309.92	1.2021
Advena Living on Woodlawn	Wichita	235.33	0.9788
Ascension Living Via Christi Village	Wichita	340.67	1.2874
Ascension Living Via Christi Village	Wichita	344.82	1.4145
Avita Health & Rehab of Reeds Cove	Wichita	333.21	1.3027
Azria Health Wichita	Wichita	372.31	1.5389
Caritas Center	Wichita	314.21	0.9342
Excel Healthcare and Rehab Wichita	Wichita	303.72	1.2486
Family Health & Rehabilitation Center	Wichita	368.75	1.3597
Homestead Health Center, Inc.	Wichita	361.85	1.4903
Lakepoint Wichita LLC	Wichita	322.30	1.3375
Legacy at College Hill	Wichita	276.94	1.3771
Life Care Center of Wichita	Wichita	308.30	1.3386
Lincoln Care and Rehab	Wichita	290.19	1.3404
Medicalodges Wichita	Wichita	317.34	1.2005
Meridian Rehab and Health Care Center	Wichita	250.25	1.2561
Mount St Mary	Wichita	352.87	1.2157
Regent Park Rehab and Healthcare	Wichita	341.56	1.1921
Sandpiper Healthcare and Rehab Center	Wichita	283.62	1.6032
Seville Operator, LLC	Wichita	329.28	1.6869
The Health Care Center@Larksfield Pl	Wichita	394.04	1.5850
Wichita Presbyterian Manor	Wichita	369.18	1.5700
Wilson Care and Rehab	Wilson	322.21	1.4782
F W Huston Medical Center	Winchester	221.90	1.1468
Cumbernauld Village, Inc.	Winfield	340.81	1.3298
Kansas Veterans' Home	Winfield	367.44	1.3543
Winfield Rest Haven II LLC	Winfield	331.96	1.2545
Winfield Senior Living Community	Winfield	312.56	2.1826
Yates Operator, LLC	Yates Center	259.78	1.3279

III. Justifications for the Rates

1. The revised final rates are calculated according to the rate-setting methodology in the Kansas Medicaid State Plan and pending amendments thereto.

2. The revised final rates are calculated according to a methodology which satisfies the requirements of K.S.A. 39-708c(x) and the DHCF regulations in K.A.R. Article 129-10 implementing that statute and applicable federal law.

3. The State's analyses project that the rates:
   a. Would result in payment, in the aggregate of 105.74% of the Medicaid day weighted average inflated allowable nursing facility costs statewide; and
   b. Would result in a maximum allowable rate of $344.96 (for a CMI of 1.2921); with the total average allowable cost being $294.32.

c. Average Payment rate July 1, 2025	$304.47
d. Average payment rate July 1, 2024	$288.27
Amount of change	$16.20
Percent of change	5.62%

4. Estimated annual aggregate expenditures in the Medicaid nursing facility services payment program will increase approximately $42.2 million.*

5. The state estimates that the rates will continue to make quality care and services available under the Medicaid State Plan at least to the extent that care and services are available to the general population in the geographic area. The state's analyses indicate:

   a. Service providers operating a total of 293 nursing facilities and hospital-based long-term care units (representing 96.07% of all the licensed nursing facilities and long-term care units in Kansas) participate in the Medicaid program;

   b. There is at least one Medicaid-certified nursing facility and/or nursing facility for mental health, or Medicaid-certified hospital-based long-term care unit in 95 of the 105 counties in Kansas;

   c. The statewide average occupancy rate for nursing facilities participating in Medicaid is 81.54%;

   d. The statewide average Medicaid occupancy rate for participating facilities is 60.82%; and

   e. The rates would cover 104.01%** of the estimated Medicaid direct health care costs incurred by participating nursing facilities statewide.

6. Federal Medicaid regulations at 42 C.F.R. 447.272 impose an aggregate upper payment limit that states may pay for Medicaid nursing facility services. The state's analysis indicates that the methodology will result in compliance with the federal regulation.

*Includes Medicaid Add-On; see A.2.

**Includes Long Term Care Rapid Response Staffing Support Center grant.

7. The Federal fiscal impact for Fee for Service is as follows:

Fee-For-Service Only	Estimated Federal Financial Participation
FFY 2025 (July-Sept 2025	($729,292)
FFY 2026 (Oct-June)	$630,716

IV. Response to Comments Received

The state did not receive formal comments to its Proposed Nursing Facility rates published on April 10, 2025 in the Kansas Register. The review of this final notice ends on July 12, 2025.

V. Notice of Intent to Amend the Medicaid State Plan

The state intends to submit Medicaid State Plan amendments to CMS on or before September 30, 2025.

Laura Howard
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Kansas Department for Aging and Disability Services

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