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LOBBYING REPORT

Lobbying Disclosure Act of 1995 (Section 5) - All Filers Are Required To Complete This Page

1. Registrant Name Baker Healthcare Consulting, Inc.			
2. Address <input type="checkbox"/> Check if different than previously reported One American Square, Suite 2000, Box 82058			
3. Principal Place of Business (if different from line 2) City: Indianapolis State/Zip (or Country) Indiana 46282			
4. Contact Name	Telephone	E-mail (optional)	5. Senate ID #
Dale E. Baker	317-631-3613	bakerhealthcare@yahoo.com	5164
7. Client Name <input type="checkbox"/> Self			6. House ID #
Fort Hamilton-Hughes Memorial Hospital			33560

TYPE OF REPORT 8. Year 2008 Midyear (January 1-June 30) OR Year End (July 1-December 31)

9. Check if this filing amends a previously filed version of this report

10. Check if this is a Termination Report ⇒ Termination Date 12-31-03 11. No Lobbying

INCOME OR EXPENSES - Complete Either Line 12 OR Line 13

12. Lobbying Firms

INCOME relating to lobbying activities for this reporting period was:

Less than \$10,000

\$10,000 or more ⇒ \$ _____
Income (nearest \$20,000)

Provide a good faith estimate, rounded to the nearest \$20,000, of all lobbying related income from the client (including all payments to the registrant by any other entity for lobbying activities on behalf of the client).

13. Organizations

EXPENSES relating to lobbying activities for this reporting period were:

Less than \$10,000

\$10,000 or more ⇒ \$ _____
Expenses (nearest \$20,000)

14. REPORTING METHOD. Check box to indicate reporting method. See instructions for description of method.

Method A. Reporting amounts using LDA definition

Method B. Reporting amounts under section 6033(e) Internal Revenue Code

Method C. Reporting amounts under section 162(e) Internal Revenue Code

Signature Dale E. Baker

Printed Name and Title Dale E. Baker, President

LD-2 (REV. 6/98)

PAC

Registrant Name Baker Healthcare Consulting Client Name Fort Hamilton-Hughes Memorial Hosp

LOBBYING ACTIVITY. Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, information as requested. Attach additional page(s) as needed.

15. General issue area code MMM (one per page)

16. Specific lobbying issues
See Attached

17. House(s) of Congress and Federal agencies contacted Check if None
Senate
House of Representatives

18. Name of each individual who acted as a lobbyist in this issue area

Name	Covered Official Position (if applicable)
Dale E. Baker	
John C. Render	

19. Interest of each foreign entity in the specific issues listed on line 16 above Check if None

D. E. Baker

2-17-04

COUNTYWIDE RECLASSIFICATION EXECUTIVE SUMMARY

In 1989 Congress established the Medicare Geographic Classification Review Board specifically instructed the Department of Health and Human Services, Centers for Medicare Medicaid Services (CMS) to provide for countywide reclassifications. CMS promulgated regulations limiting counties eligible for these reclassifications to a county included in a PM that is a part of a CMSA (a short list of counties adjacent to large urban areas such as Chicago, New York City and Los Angeles. Accordingly, CMS established criteria to demonstrate that countywide costs are "comparable" to the area to which the county seeks redesignation. CMS chose to develop formulas comparing countywide costs per discharge to the Prospective Payment System (PPS) rates that hospitals were paid in both the home geographic area and secondly, the rate they would be paid if the hospitals were reclassified. If the countywide cost per case exceeded the base rate plus 75% of the difference between the base rate and the reclassified rate - then the county hospitals met this criteria for reclassification. CMS used *rates as a proxy for costs*.

In FFY 1995 twenty-three counties were granted countywide reclassifications. Starting in 1996, the number of countywide reclassifications began to plummet because the relationship of costs to rates has changed over time. The site of care has shifted to outpatient for many services and hospitals have greatly expanded the outpatient units. Also, many hospitals have opened post acute care units (SNF, psych, rehab, home health) and now allocate fixed overhead costs to these newer units instead of the fixed costs being fully absorbed by the inpatient PPS unit. The result of this is that counties are denied reclassification simply because of the change in how medicine is practiced in the twenty-first century compared to earlier years.

In 1999, Congress granted two-year reclassifications in Section 152 of the BBRA to four counties (Lake County, Indiana; Butler County, Ohio; Brazoria County, Texas; and Orange County, New York) that could no longer meet the countywide criteria. Through administrative action CMS extended these reclassifications through September 30, 2003.

These "Section 152 hospitals" are seeking either a permanent reclassification or a renewal of the earlier reclassifications.

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