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SECRETARY OF THE SENATE

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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) Indianapolis IN 46282 City: State/zip (or Country)			
4. Contact Name Dale E. Baker	Telephone (317) 631-3613	E-mail (optional) bakerhealthcare@yahoo.com	5. Senate ID # 5164
7. Client Name: <input type="checkbox"/> Self St. Catherine Hospital			6. House ID # 33560

TYPE OF REPORT 8. Year 2004 Midyear (January 1-June 30) OR Year End (July 1-Dec

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

10. Check if this is a Termination Report ⇨ Termination Date 6/30/04

11. No Lobbyi

INCOME OR EXPENSES - Complete Either Line 12 OR Line 13

12. Lobbying Firms	13. Organizations
<p>INCOME relating to lobbying activities for this reporting period was:</p> <p>Less than \$10,000 <input checked="" type="checkbox"/></p> <p>\$10,000 or more <input type="checkbox"/> ⇨ \$ _____ Income (nearest \$20,000)</p> <p>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).</p>	<p>EXPENSES relating to lobbying activities for this reporting period were:</p> <p>Less than \$10,000 <input type="checkbox"/></p> <p>\$10,000 or more <input type="checkbox"/> ⇨ \$ _____ Expenses (nearest \$20,000)</p> <p>14. REPORTING METHOD. Check box to indicate accounting method. See instructions for description of</p> <p><input type="checkbox"/> Method A. Reporting amounts using LDA definition</p> <p><input type="checkbox"/> Method B. Reporting amounts under section 6033 Internal Revenue Code</p> <p><input type="checkbox"/> Method C. Reporting amounts under section 162 Internal Revenue Code</p>

Signature Walter E. Baker Date August 23, 2004

Printed Name and Title Dale E. Baker, President

LD-2 (REV. 4/03)

PAGE 1 of 8

Registrant Name Baker Healthcare Consulting, Inc. Client Name St. Catherine Hospital

LOBBYING ACTIVITY. Select as many codes as necessary to reflect the general issue areas in which t engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each c 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	
Robert Grand	
William Moreau	

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

Signature Dale E. Baker Date 8-23-04
Filing #a9963ec3-45a1-4fec-bd4a-b3dac30767ba - Page 3 of 8

Signature _____

Printed Name and Title Dale E. Baker President

Form LD-2 (Rec. 4/03)

Page _____

Registrant Name Baker Healthcare Consulting, Inc. Client Name St. Catherine Hospital

Information Update Page - Complete ONLY where registration information has changed.

20. Client new address

21. Client new principal place of business (if different from line 20)

City _____ State/Zip (or Country) _____

22. New general description of client's business or activities

LOBBYIST UPDATE

23. Name of each previously reported individual who is no longer expected to act as a lobbyist for the client

ISSUE UPDATE

24. General lobbying issues previously reported that no longer pertain

AFFILIATED ORGANIZATIONS

25. Add the following affiliated organization(s)

Name	Address	Principal Place of Business (city and state or country)

26. Name of each previously reported organization that is no longer affiliated with the registrant or client

FOREIGN ENTITIES

27. Add the following foreign entities

Name	Address	Principal place of business (city and state or country)	Amount of contribution for lobbying activities

28. Name of each previously reported foreign entity that no longer owns, or controls, or is affiliated with the registrant, affiliated organization

Signature *De E. Bahr*

Date 8/23/2004

Signature _____

Printed Name and Title Dale E. Baker, President

Form LD-2 (Rev. 4/03)

Page _____

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 and Medicaid Services (CMS) to provide for countywide reclassifications. CMS promulgated regulations limiting counties eligible for these reclassifications to a county included in a FIPS 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 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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