BAKER HEALTHCARE CONSULTING, INC.
SUITE 2000, BOX 82058
ONE AMERICAN SQUARE
INDIANAPOLIS, INDIANA
46282

DALE E. BAKER
PRESIDENT

March 5, 2003

Secretary of the Senate
Office of Public Records
232 Hart Building
Washington, DC 20510

Re: Untimely Filing of LD-2 for Year End 2002 Reports

Dear Secretary:

Baker Healthcare Consulting, Inc. is a very small firm with one full-time employee, I Baker, and one full-time leased employee, Karen K. Siders. Ms. Siders' father had surgery l in January 2003 and died on Tuesday, February 25, 2003. Ms. Siders used the Family Medi Leave Act to be with her father and her family throughout this most difficult period.

As a result, normal secretarial activities were delayed and the reports were not filed d to an oversight by Dale E. Baker.

We hope that we have not inconvenienced your office with this oversight. Our intent always been, is, and will continue to be, to fully comply with the Lobbying Disclosure Act o 1995 and its interpretation.

Sincerely,

BAKER HEALTHCARE CONSULTING, INC.

Dale E. Baker

Dale E. Baker

Enclosures

20868_1.DOC

Clerk of the House of Representatives	Secretary of the Senate
Legislative Resource Center	Office of Public Records
B-106 Cannon Building	232 Hart Building
Washington, DC 20515	Washington, DC 20510

-SECRETAR.
03 MAR 13

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 ☐ 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) IN 46282

4. Contact Name: Dale E. BAKER Telephone: 317-631-3613 E-mail (optional): BAKERHealthcare@YAHOO.COM

5. Senate ID # 5164

6. House ID # 3356

7. Client Name ☐ Self
Cortland Memorial Hospital, Cortland, NY

TYPE OF REPORT 8. Year 2002 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 12-31-02 11. No Lobbyin

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 re period were:

Less than $10,000 ☐

$10,000 or more ☐ ⇨ $_____
Expenses (nearest

14. REPORTING METHOD. Check box to indicat accounting method. See instructions for description o

☐ **Method A.** Reporting amounts using LDA defini

☐ **Method B.** Reporting amounts under section 603 Internal Revenue Code

☐ **Method C.** Reporting amounts under section 162 Internal Revenue Code

Signature Dale E. Baker

Printed Name and Title Dale E. BAKER, President

LD-2 (REV. 6/98) P

Registrant Name Baker Healthcare Consulting Client Name Cortland Memorial Hosp

LOBBYING ACTIVITY. Select as many codes as necessary to reflect the general issue areas in which th engaged in lobbying on behalf of the client during the reporting period. **Using a separate page for each co** 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	

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

Signature Dale E. Baker Date March 6, 2

Printed Name and Title Dale E. BAKER

Form LD-2 (Rev 6/98)

Registrant Name BAKER Healthcare Consulting Client Name Cortland Memorial H

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 B (city and state or c

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 registrar affiliated organization

Signature Dale E. Baker Date March 6, 200

Printed Name and Title Dale E. Baker, President

EXECUTIVE SUMMARY

Cortland Memorial Hospital is a 181-bed hospital located in Cortland, N York. The hospital is designated a Sole Community Hospital but is located in competitive market area with a number of hospitals in the nearby Syracuse Metropolitan Area and another hospital located in Ithaca. Cortland Memorial Hospital is the only hospital in the market that does not qualify for Medicare payment using the Syracuse wage index.

The payment rates for this hospital are almost $400 per discharge less th the other hospitals in the area. This places Cortland Memorial at a significant disadvantage in a competitive marketplace in attracting and retaining health ca professionals that are in short supply.

The hospital seeks a statutory reclassification to receive the Syracuse wa index to level the playing field and allow Cortland Memorial to offer a compet package to compete effectively for scarce labor resources. The "Section 152" hospitals that were approved for a statutory reclassification in 1999 in the BBR are expected to be requesting Congress to renew these reclassifications in legislation this fall. If other hospitals are added to the list of the existing Secti 152 hospitals, Cortland requests inclusion on any such list.

CORTLAND MEMORIAL HOSPITAL
134 Homer Avenue • PO Box 2010 • Cortland, New York 13045-0960
(607) 756-3500

July 2, 2001

Mr. Thomas Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
HCFA-1163-P
P.O. Box 8013
Baltimore, MD 21244-8010

Ref: HCFA-1163-P – Medicare Program Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities

Dear Mr. Scully:

I am the President and Chief Executive Officer of Cortland Memorial Hospital, a 181-bed sole community hospital located in Cortland, New York. Cortland Memorial Hospital provides general medical and surgical services, psychiatric services, skilled nursing services, outpatient services, and home health services to this rural upstate New York community. I am writing to ask you to revise the proposed rules transitioning swing beds to SNF PPS that were published in the *Federal Register* May 10, 2001 by: 1) allowing sole community hospitals (SCHs) the option of electing whether to remain in the current cost-based system for swing beds or to switch to the SNF PPS system and 2) for those swing bed facilities switching to SNF PPS, allowing the 9-category, claims-based RUGS (proposed by the American Hospital Association) as a voluntary option instead of the requirement to use the Minimum Data Set (MDS) to classify patients.

SCH Election of Cost-Based or SNF PPS for Swing Beds

The Centers for Medicare & Medicaid Services (CMS) historically has recognized the importance of SCHs in providing health care in isolated rural areas by providing special reimbursement rules specific to SCHs. The capital safety net during the capital PPS transition period, the enhanced lab fee schedule, and the recent addition of the 1996 cost base year election are examples of some of these rules. All of these illustrate CMS' commitment to the continued well being of the sole community providers. A CMS analysis of the financial impact of SNF PPS on swing bed hospitals indicates that SNF PPS would increase payments to swing bed hospitals by 9% or $20 million in total. I don't believe it is CMS' intention to harm SCHs with the transition of swing beds to the SNF PPS. This is why I am requesting that each SCH be given the option to elect whether to remain on the current cost-based system or move to the SNF PPS. CMS has decided to leave critical access hospitals (CAH) on the current system, so the mechanism for annual cost settlements is still going to be in place.

Our service area has four skilled nursing facilities that review our patients on a daily basis for admission to their facilities. The area SNFs try to admit the higher RUGS patients, particularly rehabilitation patients. While Cortland Memorial Hospital has 97 beds that can be used interchangeably for acute and short-term skilled care depending on patient need, we have an average swing bed census of approximately 14 patients with an average length of stay of 15 days. Approximately 45% of our swing days are Medicare days and these days fall into the lower 22 RUGS categories, (those that are least desired by the SNFs). National data showing swing days spread throughout the RUGS categories does not apply to our facility. We have estimated that our daily Medicare swing bed rate will decrease by approximately 35-40% if we switch to the SNF PPS system because of our patient mix falling into these

lower RUGS categories. This is a loss of $190,000 annually. Other SCHs may have a higher RUGS mix, so the SNF PPS may benefit them.

9-Category, Claims-Based RUGS Option

For those swing facilities adopting SNF PPS, I disagree with the requirement that swing-hospitals complete the MDS when admitting a patient to a swing bed. The purpose of the MDS i assess patients, monitoring their improvement in activities of daily living over a long period of ti Such an assessment is appropriate in a skilled care facility with longer lengths of stay of several week months, not a length of stay of less than 2 weeks. While some swing hospitals have hospital-based ski nursing facilities with MDS experience, others do not. We have a hospital-based SNF and M experience, but still estimate that completing the additional MDS forms and monitoring the paperw would cost us approximately $12,000 annually.

The government continually burdens the providers with complex rules and regulations increase costs and deter efforts of providers to provide quality patient care. The proposed swing-bed I MDS requirement comes on top of other equally burdensome regulations such as OASIS for home he services and APCs for the new outpatient PPS. The proposed requirement to use the MDS, if not revi will overwhelm hospital staff with pages of unnecessary paperwork while not advancing the goa improving patient outcomes.

I believe it is possible to classify patients into far fewer categories for payment purposes witl imposing this requirement on facilities that are trying to do the best they can with limited resource take care of patients in their own community and not send them far from home for the skilled care I need. Let caregivers be caregivers. I encourage you to consider the option developed by the Amer Hospital Association to use fewer payment categories and pay swing beds using less data than minimum data set.

Thank you for your consideration of these two revisions.

Sincerely,

Thomas Carman
President/CEO

dw

pc: Congressman James T. Walsh
Senator Hillary Rodham Clinton
Senator Charles Schumer
American Hospital Association
Healthcare Association of New York State